

INDIAN HEALTH SERVICE

Patient and Family Education Protocols and Codes

SURGERY & ANESTHESIA CODES

9th Edition

June 2003

FOREWORD TO THE 9TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

The PEP-C (Patient Education Protocols and Codes committee) has diligently worked to add all protocols that were requested by providers or departments. We hope that you find codes helpful in documenting your patient education. Some of the codes found in this book will be used in ORYX and GPRA as indicators. Please consult your local SUD to see which indicators your site has chosen. More information about these topics can be obtained from Mary Wachacha or Mike Gomez. They are both in the IHS e-mail system.

As co-chairs of this committee we would like to sincerely thank all the members and guests of this committee. As usual they spent long hours preparing for the committee meeting and even longer hours in committee. They all deserve our appreciation. Without these dedicated committee members this would not be possible. We would also like to again thank Mary Wachacha, IHS Chief of Health Education. Without her vision (and financing) none of this would be possible. We would like to recognize Liz Dickey, R.N. for her part in envisioning an easier way to document education. We would like to thank Juan Torrez for his assistance in formatting and ensuring consistency in our document. We would like to thank all the programs in IHS for their dedication to the documentation of patient and family education. Finally, we are indebted to our colleagues in the Indian Health Service for their support, encouragement and input.

If you have new topics or codes you would like to see in future editions of the Patient Education Protocols and Codes please let us know. Submissions are requested and encouraged!!! Please e-mail submissions or mail them on floppy disk, in Word or Word Perfect format. Please try to follow the existing format as much as possible and as much as possible use mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

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FOREWORD TO THE 9TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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TOP LEVEL PEPC TOPICS

Abdominal Pain	Gastroesophageal Reflux Disease
Advance Directives	GI Bleed
Anemia	Hypertension
Anesthesia	Injuries
Blood Transfusion	Laboratory
Cancer	Obesity
Chronic Pain	Pain Management
Crohn's Disease	Pancreatitis
Diabetes Mellitus	Radiology/Nuclear Medicine
Diverticulitis/Diverticulosis	Skin and Wound Infections
Dysrhythmias	Surgical Procedures and Endoscopy
Fever	Tobacco Use
Frostbite	Ulcerative Colitis
Gallbladder Disorders	

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES**WHY USE THE CODES**

Use of the codes helps nurses, physicians and other health care providers to document and track patient education. While it is frequently desirable to spend 15, 30 even 60 minutes making an assessment of need, providing education and then documenting the encounter, the reality of a busy clinical practice often requires us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting that education took place during a given patient visit. The codes are then transferred to the health summary which informs everyone using the chart that a given patient received education on specific topics. The codes are limited in that they do not detail the exact nature of the education. However, using these codes consistently will show the pattern of education provided and encourage subsequent health professionals to do the appropriate follow-up. For instance, a typical health summary for a diabetic patient might show the following history of patient education:

07/19/97 DM-Diet, poor understanding
10/27/97 DM-Foot care, good understanding
02/07/98 DM-Exercise, good understanding
05/10/98 DM-Diet, fair understanding

A reasonable interpretation of this summary tells you that this patient is trying to understand dietary management of their diabetes but does not yet fully grasp the concepts. It should lead subsequent providers to spend more time reinforcing dietary guidelines.

SOAP CHARTING AND THE CODES

Use of the codes *does not* preclude writing a SOAP note on educational encounters. Whenever a health professional spends considerable time providing education in a one-on-one setting, that visit should be recorded as an independent, stand-alone visit. The primary provider can incorporate the educational information into their SOAP note and use the code to summarize the visit and get the information onto the health summary. If the patient sees both a physician and a nurse during the same visit and the nurse does a lengthy educational encounter, two PCC forms should be used—one for the physician visit and one for the nursing visit. In that particular case the patient had two primary care encounters during the same day.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

HOW TO USE THE CODES

The Medical Records and Data Entry programs at each site determine where patient education will be entered on the PCC and other facility forms. Medical Records and Data Entry will also determine how the patient education is recorded, i.e., each educational encounter is to be written on a separate line on the PCC or the patient education is to be written in a “string” on the same line followed by a hyphen (-) or a comma (.). You should check with your Medical Records and Data Entry staff to determine how they would like your facility to document patient education. Using a stamp, over-printing on the PCC or the use of “education flow sheets” is discouraged for all disciplines and all sites. All education should be documented directly onto the PCC.

The educator should document the education using the following steps:

1. Log onto the PCC form using the sign-in box in the upper right-hand corner.
2. Circle “Patient Education” in the section marked
“Medications/Treatment/Procedures/Patient Education”
3. Begin your documentation by entering the appropriate:
 - a. ICD-9 code,
 - b. disease state,
 - c. illness or condition for which you are providing the education followed by a hyphen (-) or a comma (,) or in whatever manner your Medical Records or Data Entry staff requests providers to document.
 - i. Examples include writing out in long-hand the disease state, illness or condition - “Tobacco dependence,”
 - ii. Writing out the ICD-9 Code - 250.00 (ICD-9 code for diabetes),
 - iii. Or, writing the “condition” such as head lice.
4. Next, enter the education topic discussed (e.g. complications, nutrition, hygiene) also followed by a hyphen (-) or a comma (,) or in whatever manner your Medical Records or Data Entry staff requests.
5. Determine the patient’s level of understand of the education provided and enter as good- (G), fair (F), or Poor (P) followed by a hyphen (-) or a comma (,) using either the comma or hyphen as directed by your Medical Records or Data Entry staff.
6. If the patient refuses the education encounter, you document this refusal by writing an (R) for refused.
7. If you are providing education in a group (not an individual one-on-one encounter), the education provided is documented as (GP) for Group education. A “group” is defined as more than one person.
8. Enter the amount of Time spent educating the patients. Use specific time amounts rounded off to the minute; 3 minutes, 17 minutes, etc.
9. Initial your entry so that you can get credit for the education provided.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

10. Lastly, each provider is able to encourage the patient to participate in the determination of their personal health by setting a goal for themselves. This is capability is the last item documented at the end of the educational encounter. The provider assists the patient in setting “plan of action” for themselves to aid in the improvement of their health. This documented by using (GS) for Goal Set; (GM) for Goal Met; and (GNM) for Goal Not Met. Upon the documentation of the setting of a Goal, each subsequent health care provider can refer to the “Health Summary” and look under the “Most Recent Patient Education” to review any goals set by the patient.

OBJECTIVE	DEFINITION	MNEMONIC
Goal Set	<ul style="list-style-type: none">• State a plan;• State a plan how to maintain at least one _____;• Write a plan of management;• Plan to change _____;• A plan to test _____(blood sugar);• Choose at least one change to follow _____;• Demonstrate _____ and state a personal plan for _____;• Identify a way to cope with _____;	GS
Goal Met	Behavior Goal Met	GM
Goal Not Met	Behavior Goal Not Met	GNM

11. It is important to note that if you educate a patient on more than one topic within a category (i.e., Diabetes, Medicines [M] and Diabetes, Lifestyle Adaptation [LA]) these can be separated by a comma or a hyphen (DM-M, LA, Level of Understanding -Time-Your Initials-GS). This is only true if the patient’s level of understanding is the same for all topics. Otherwise separate entries must be made.

The PCC Coders can only select “Good, Fair, Poor, Group or Refused” for the level of understanding. Remember, this section is meant for speedy documentation of brief educational encounters. If you wish to write a more lengthy narrative, please do so, on a separate PCC form using the codes to simply summarize your note. On inpatient PCCs each entry must be prefaced by a date.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

RECORDING THE PATIENT'S RESPONSE TO EDUCATION

The following “Levels of Understanding” can be used in the PCC system:

- | | |
|----------------------|---|
| Good (G): | Verbalizes understanding
Verbalizes decision or desire to change (plan of action indicated)
Able to return demonstrate correctly |
| Fair (F): | Verbalizes need for more education
Undecided about making a decision or a change
Return demonstration indicates need for further teaching |
| Poor (P) | Does not verbalize understanding
Refuses to make a decision or needed changes
Unable to return demonstrate |
| Refuse (R): | Refuses education |
| Group (Gp): | Education provided in group. Unable to evaluate individual response |

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

Implementation date:
Revised:

Review interval: Every year
Responsible person: PFE Committee
Chapter:
Section:

I. Purpose:

To enhance multidisciplinary documentation and communication of patient and family education.

II. Policy:

Multidisciplinary team members provide patient and family education. The teaching process is documented differently in ambulatory and inpatient settings.

Staff members document patient education through the use of “IHS Patient Education Protocols and Codes.”

Staff members document “Education Assessment Codes” on the PCC and PCC+ form. Educational Assessment Codes are used to document patient learning preferences, barriers to learning and readiness to learn.

- Patient Readiness to Learn is assessed and documented for every teaching encounter
- Learning Preferences and Barriers to Learning are reassessed and documented annually.

The RPMS “Health Summary” contains a section in which patient education is summarized. Multidisciplinary team members can determine individual’s previous instruction and learning by reviewing this information.

III. Procedure

Education and assessment information are recorded on documents depending on the care setting:
Inpatient care – the “Multidisciplinary Patient and Family Education Record”

Outpatient care – the “PCC Ambulatory Encounter Record”

Emergency care – the “Emergency Visit Record”

Ambulatory surgery – the “PCC Pre-op Anesthesia Evaluation” form

A. Multidisciplinary Patient and Family Record - Inpatient form:

1. The Inpatient form is part of the patient’s permanent medical record.
2. The form is included in the inpatient admission packet. (The form is initiated in the Emergency Department if the patient is admitted through the ER.)
3. The form is used to document all of the patient education that is provided from admission through discharge.
4. The patient’s name and medical record number are documented on the form in the lower left corner under “addressograph”.
5. The original white copy of the form remains in the inpatient record after discharge.
6. Data entry clerks receive the pink copy of the form. They enter education that is noted on the form.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

7. The initial In-Patient education assessment is completed within 12 hours of admission.
8. Results of the education assessment (i.e., Readiness to Learn, Learning Preferences, and Barriers to Learning) are documented on the appropriate section of the form.
9. Providers document patient education provided by noting: date and time, ICD-9 Codes, disease state, illness or condition, the Patient Education topic(s), and level of understanding, the time spent in teaching, the patient or person(s) taught and whether a behavior goal was set. Enter the appropriate CPT code if known.
10. The person (s) who receive (s) instruction is/are noted in the column marked “person taught”. If a person other than the patient is taught, their relationship with the patient is written.
11. If additional documentation of a teaching encounter is needed, the small box in the “Patient Education Codes” column is checked. Additional documentation is then written in the Progress Note.
12. Provider signature and core are noted for each entry.

B. PCC Ambulatory Encounter Record; Emergency Visit Record; Pre-Op Anesthesia Evaluation Record:

Providers use either the “PFE box,” or lower portion of the PCC to document readiness to learn, learning preferences, barriers to learning, PFE topic, and level of understanding.

C. General Considerations:

1. Multiple topics may be entered on one line or box only if the patient response is the same. If the patient response varies for different topics taught, only one topic is entered per line, with the appropriate response.
2. Follow-up education is determined based on patient/family’s response to education received.

APPROVAL:

Chair, Patient & Family Education Committee

Date

Nurse Executive

Date

Clinical Director

Date

Professional Service Director

Date

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

Documenting Patient Education and Educational Assessment on the PCC Inpatient Supplement and Discharge Follow-Up Record form (Figure 1):

1. Document the Educational Assessment in the Problem List Additions or Changes field.
2. Document the Patient Education in the Problem List Additions or Changes field underneath the Educational Assessment.
3. It is important to place your provider code and signature on the bottom of the PCC form.

Documenting Patient Education and Educational Assessment on the PCC Ambulatory Encounter Record form (Figure 2):

There are two places on the PCC form where it is appropriate to document patient education.

1. Document the Educational Assessment in the Purpose of Visit field or in the Medications/Treatments/Procedures/Patient Education field toward the bottom of the form.
2. Document the Patient Education in the Purpose of Visit field or in the Medications/Treatments/Procedures/Patient Education field toward the bottom of the form underneath the Educational Assessment.
3. It is also important to place your provider code in the top right hand corner and to sign the bottom of the PCC form.

Documenting Patient Education and Educational Assessment on a PCC+ form (Figure 3 and Figure 4):

1. Document Educational Assessment in the Learning Preferences, Barriers to Learning, and Readiness to Learn fields.
2. Document the Patient Education in the Patient Education table.
3. It is important to place your provider code in the top right-hand corner of the PCC + form, and sign at the bottom right-hand of the PCC+ form.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

IHS-485
(3/98)

**PCC INPATIENT SUPPLEMENT AND
DISCHARGE FOLLOW-UP RECORD**

1

Document Educational Assessment here

**Learning Preferences – TALK
PED – HTN – LA – G – XYZ – 5 min – GS**

PROBLEM LIST

A-A-C	#	PROBLEM LIST ADDITIONS OR CHANGES	(PRINT ONLY IN THIS SECTION)

REPRODUCTIVE FACTORS

G	P	LC	SA	TA	LMP	FP METHOD	DATE BEGUN

PROBLEM LIST NOTES

STORE NOTE FOR PROB. #

STORE NOTE FOR PROB. #

A. DISCHARGE ORDER

2

Document the Patient Education here

DATE OF ORDER #

B. DIAGNOSES AND PROBLEMS

C. OPERATIONS AND / OR PROCEDURES

D. CONDITION AT DISCHARGE

E. MEDICATION, SPECIAL EQUIPMENT, SUPPLIES FOR USE AT HOME

F. FOLLOW-UP RECOMMENDATIONS, SPECIFIC INSTRUCTIONS, DIET, ACTIVITY, WORK TOLERANCE, REFERRALS, RETURN APPOINTMENT

I, _____
(Patient or Representative)
the above instructions

ADMISSION

DISCHARGE DATE

PROVIDER SIGNATURE

PROVIDER CODE

APL

Da

Initials/Code

X Y Z

It is important to place your provider code and signature on the bottom of the PCC form.

Signature

Don't know how to document educational assessments?
Please refer to the IHS Patient Education Protocol Manual
#1 Educational Assessment
#2 Patient Education

Change to Inactive #

Change to Active #

B/P

BREAST

RECTAL

HEP Bf

HEP Af

OPVf

DTFf

DTaf

DT

Td

MMPf

VARICELLA

HELVIXIA

Figure 1: Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

IHS-303 (10/98) PL 98-011 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date: _____ AM
 Arrived Time: _____ PM
 Clinic: _____
 Appt: _____

PROBLEM LIST UPDATE
 (Enter Problem Numbers From Health Summary)

Remove: _____ Move to Inactive: _____ Move to Active: _____

PROVIDERS: _____
 PRIMARY PROVIDER: _____

APPL: _____
 IML: _____
 INITIALS / CODE: **XYZ**

TEMP: _____ PULSE: _____ RESP: _____

BP: _____
 WT: _____
 HT: _____
 HEAD: _____
 VISION - UNCORRECTED: _____
 VISION - CORRECTED: _____

CHIEF COMPLAINT: _____
 SUBJECTIVE: _____
 OBJECTIVE: _____

Injury? ☐ Yes ☐ No If yes, Date: _____ ETOH Related ☐ Employ. Rel. ☐

Cause: _____ Place: _____
 (For additional Documentation, see IHS 48-3 Continuation Sheet)

OTHER TESTS/PROCEDURES/ORDERS: _____

PROBLEM LIST: _____

PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)

Learning Preference - TALK
PED - HTN - LA - G - XYZ - 5 min - GS

REPRODUCTIVE FACTORS: _____

PROBLEM LIST NOTES: _____

STORE NOTE FOR PROB. # _____

MEDICATIONS: _____

DATE BEGUN: _____

REMOVE NOTE # _____

DATE: _____ TIME: _____

NAME: _____

SSN # _____

SEX: _____

TRIBE: _____

RESIDENCE: _____

FACILITY: _____

INSTRUCTIONS TO PATIENT: _____

SKIN RELEASE RECORDS: ☐

PROB. SIGNATURE: _____

Signature

Or Document the Patient Education and Assessment

Document Educational Assessment here

Document the Patient Education Here

Educational Assessments questions? Please refer to the IHS Patient Education Protocol Manual

Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

9th edition June 2003

Figure 3: Documenting Patient Education on a PCC+ form, page 1

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

«hdr»		«time stamp»		«provider»	
X	Treatment/Procedures	CPT	Supplies	Qty	CPT
«t1»	«t1a»	«t1b»	«t1c»	«t1d»	«t1e»
«t2»	«t2a»	«t2b»	«t2c»	«t2d»	«t2e»
«t3»	«t3a»	«t3b»	«t3c»	«t3d»	«t3e»
«t4»	«t4a»	«t4b»	«t4c»	«t4d»	«t4e»
«t5»	«t5a»	«t5b»	«t5c»	«t5d»	«t5e»
«t6»	«t6a»	«t6b»	«t6c»	«t6d»	«t6e»
«t7»	«t7a»	«t7b»	«t7c»	«t7d»	«t7e»
«t8»	«t8a»	«t8b»	«t8c»	«t8d»	«t8e»
«t9»	«t9a»	«t9b»	«t9c»	«t9d»	«t9e»
«t10»	«t10a»	«t10b»	«t10c»	«t10d»	«t10e»
«t11»	«t11a»	«t11b»	«t11c»	«t11d»	«t11e»
«t12»	«t12a»	«t12b»	«t12c»	«t12d»	«t12e»
«t13»	«t13a»	«t13b»	«t13c»	«t13d»	«t13e»
«t14»	«t14a»	«t14b»	«t14c»	«t14d»	«t14e»
«t15»	«t15a»	«t15b»	«t15c»	«t15d»	«t15e»
«t16»	«t16a»	«t16b»	«t16c»	«t16d»	«t16e»
«t17»	«t17a»	«t17b»	«t17c»	«t17d»	«t17e»

Purpose of Visit		Prioritize POV = ["1-2-3..."]	Add Active Problems = ["A"]	Inactivate Problem = ["I"]	Remove Problem = ["R"]
A / I / R	ICD-9	Active Problems & POVs	A / I / R	ICD-9	ICD-9 Pick List
«p1»	«p1a»	«p1b»	«p1c»	«p1d»	«p1e»
«p2»	«p2a»	«p2b»	«p2c»	«p2d»	«p2e»
«p3»	«p3a»	«p3b»	«p3c»	«p3d»	«p3e»
«p4»	«p4a»	«p4b»	«p4c»	«p4d»	«p4e»
«p5»	«p5a»	«p5b»	«p5c»	«p5d»	«p5e»
«p6»	«p6a»	«p6b»	«p6c»	«p6d»	«p6e»
«p7»	«p7a»	«p7b»	«p7c»	«p7d»	«p7e»
«p8»	«p8a»	«p8b»	«p8c»	«p8d»	«p8e»
«p9»	«p9a»	«p9b»	«p9c»	«p9d»	«p9e»
«p10»	«p10a»	«p10b»	«p10c»	«p10d»	«p10e»
«p11»	«p11a»	«p11b»	«p11c»	«p11d»	«p11e»
«p12»	«p12a»	«p12b»	«p12c»	«p12d»	«p12e»
«p13»	«p13a»	«p13b»	«p13c»	«p13d»	«p13e»
«p14»	«p14a»	«p14b»	«p14c»	«p14d»	«p14e»
«p15»	«p15a»	«p15b»	«p15c»	«p15d»	«p15e»
«p16»	«p16a»	«p16b»	«p16c»	«p16d»	«p16e»
«p17»	«p17a»	«p17b»	«p17c»	«p17d»	«p17e»
«p18»	«p18a»	«p18b»	«p18c»	«p18d»	«p18e»
«p19»	«p19a»	«p19b»	«p19c»	«p19d»	«p19e»

A / I / R	Additional Purpose of Visit	Plans/Instructions/Appointments/Referrals
«a1»	«a1a»	«a1b»
«a2»	«a2a»	«a2b»
«a3»	«a3a»	«a3b»
«a4»	«a4a»	«a4b»
«a5»	«a5a»	«a5b»
«a6»	«a6a»	«a6b»
«a7»	«a7a»	«a7b»
«a8»	«a8a»	«a8b»
«a9»	«a9a»	«a9b»
«a10»	«a10a»	«a10b»

Patient Education (Circle or Write in Responses for Each Column)							
Learning Preferences	TALK	Barriers to Learning	HEAR	Readiness to Learn	EAGR		
Diagnosis or Code	Topic	Level of Understanding	Provider	Time (min)	Goals	Comments	
HTN	LA	G P Group Refused	XYZ	5	65	Plans to reduce salt intake	
		G F P Group Refused					
		G F P Group Refused					
		G F P Group Refused					

X	Preventative Med	New	Estbl	X	E&M Visit Level	New	Estbl
	Infant (< 1 yr.)	99381			Level w/ an "X" and CIRCLE whether NEW or ESTABLISHED patient.		
	Early childhood (1-4 yrs.)	99382			ROS 0, 1 organ sys/body area	99202	99212
	Late childhood (5-11 yrs.)	99383			ROS 1, 2-7 o.s./b.a.	99203	99213
	Adolescent (12-17 yrs.)	99384			ROS 2-9, 2-7 o.s./b.a.	99204	99214
	18-39 yrs	99385			ROS 10-14, 8-12 o.s./b.a.	99205	99215
	40-64 yrs	99386					99211
	65 yrs & >	99387	99397		Counseling ___ 15 min. / ___ 30 min. / ___ 45 min.		9940

I HAVE RECEIVED THE ABOVE MEDICATION AND HAVE BEEN OFFERED/RECEIVED COUNSELING	Provider Signature	Signature
--	--------------------	-----------

«patient»
DOB: «dob»
«t27»

«agesex»
SSN: «ssn»
#«chart»

«timestamp»
VCN: «uid»

Figure 4: Documenting Patient Education on a PCC+ form, page 2

INPATIENT EDUCATION RECORD

READINESS TO LEARN (RL Code) Eager to Learn RL-EAGR Receptive RL-RCPT Unreceptive RL-UNRC Pain RL-PAIN Severity of Illness RL-SVIL Not Ready RL-NOTR Distraction RL-DSTR Assessed each teaching session	PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING) GOOD (G) - Verbalized understanding. Verbalizes decision to change (plan of action indicated) able to demonstrate correctly. FAIR (F) - Verbalizes need for more education. Undecided about making a decision or change. Return demonstration indicates need for further teaching. POOR (P) - Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration. REFUSED (R) - Refuses education. GROUP (GP) – Group taught
LEARNING PREFERENCES (LP Code) Assessed Yearly If Assessed Today, Today's Date:	Talk (one-on-one) LP-TALK Video LP-VIDO Group LP-GP Read LP-READ Do/Practice LP-DOIT
BARRIERS TO LEARNING - BAR (Assessed Annually); If Assessed Today, Date Assessed: Check those that apply:	
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> No Barriers BAR-NONE</div> <div style="width: 33%;"><input type="checkbox"/> Doesn't read English BAR-DNRE</div> <div style="width: 33%;"><input type="checkbox"/> Interpreter Needed BAR - INTN</div> <div style="width: 33%;"><input type="checkbox"/> Social Stressors BAR-STRS</div> <div style="width: 33%;"><input type="checkbox"/> Cognitive Impairment BAR-COGI</div> <div style="width: 33%;"><input type="checkbox"/> Blind BAR-BLND</div> <div style="width: 33%;"><input type="checkbox"/> Fine Motor Skills BAR-FIMS</div> <div style="width: 33%;"><input type="checkbox"/> Hard of Hearing BAR-HEAR</div> <div style="width: 33%;"><input type="checkbox"/> Deaf BAR-DEAF</div> <div style="width: 33%;"><input type="checkbox"/> Visually Impaired BAR-VISI</div> <div style="width: 33%;"><input type="checkbox"/> Values/Beliefs BAR-VALU</div> <div style="width: 33%;"><input type="checkbox"/> Emotional Impairment BAR- EMOI</div> </div>	
List measures taken to address above barriers: Comments: _____	

DATE	PATIENT EDUCATION	(Check box to refer to Progress Notes)	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDERSTANDING CODE	PERSON TAUGHT	TIME	GOAL SET GOAL MET GOAL NOT MET	CPT CODE
	ICD-9 CODE DISEASE STATE, ILLNESS OR CONDITION	EDUCATION TOPIC							
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
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Patient Identification					Providers please sign on back of form				

White – Chart Yellow- Billing Pink- Data Entry

INPATIENT EDUCATION FORM

[illegible]

INPATIENT EDUCATION FORM

Indian Health Service
Patient Education Assessment Codes
For use with the Ambulatory and Emergency PCC
October 2003

LP	RL	BL	Code:	Response:	Initials:

LP - Learning Preference

1. -Talk
2. -Video
3. -Small Group
4. -Read
5. -Do/Practice

Mnemonics

LP-TALK
LP-VIDO
LP-GP
LP-READ
LP-DOIT

RL - Readiness to Learn

6. -Eager
7. -Receptive
8. -Unreceptive
9. -Pain
10. -Severity of Illness
11. -Not Ready
12. -Distraction

RL-EAGR
RL-RCPT
RL-UNRC
RL-PAIN
RL-SVIL
RL-NOTR
RL-DSTR

BAR - Barriers to Learning

13. -No Barriers
14. -Doesn't Read
15. -Interpreter Needed
16. -Cognitive Impairment
17. -Fine Motor Skills Deficit
18. -Hard of Hearing
19. -Deaf
20. -Visually Impaired
21. - Blind
22. - Emotional Impairment
23. -Social Stressors
24. -Values/Belief

BAR-NONE
BAR-DNRE
BAR-INTN
BAR-COGI
BAR-FIMS
BAR-HEAR
BAR-DEAF
BAR-VISI
BAR-BLND
BAR-EMOI
BAR-STRS
BAR-VALU

INPATIENT EDUCATION FORM

P.L. 96-511 N.A.

DATE							
LOCATION	PROVIDER CODE			PROVIDER CODE			SERVICES PROVIDED
	APP.	Dis.	Instance/Code	APP.	Dis.	Instance/Code	

[illegible]

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of services can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE

NEW CODES FOR 2003

The following codes are new to the Patient Protocol and Coding Manual in the 2003 (9th) edition.

ADV **ADVANCE DIRECTIVES**

- I - [Information](#)
- L - [Patient Information Literature](#)
- LW - [Living Will](#)
- POA - [Durable Power Of Attorney for Healthcare](#)
- RI - [Patient Rights and Responsibilities](#)

AN **ANEMIA**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- M - [Medications](#)
- N - [Nutrition](#)
- PRO - [Procedures](#)
- TE - [Tests](#)
- TX - [Treatments](#)

ANS **ANESTHESIA**

- INT - [Intubation](#)

LAB **LABORATORY**

- DRAW - [Phlebotomy](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- S - [Safety](#)
- TE - [Tests](#)

MEDS **MEDICAL SAFETY**

- I - [Information](#)
- TE - [Tests](#)

XRAY **RADIOLOGY/NUCLEAR MEDICINE**

- C - [Complications](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- M - [Medications](#)
- PRO - [Procedure](#)
- S - [Safety](#)
- TE - [Tests](#)

SPE **SURGICAL PROCEDURES AND ENDOSCOPY**

- PRO - [Procedures](#)

ABD-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of abdominal pain and verbalize that they will return for additional medical care if symptoms of complication occur.

STANDARDS:

1. Explain that some possible complications are acute hemorrhage, sustained hypotension and shock, perforation of a viscus, and infections such as bacteremia.
2. Explain that complications may be prevented with prompt treatment with appropriate therapy.
3. Advise the patient/family to report increasing-pain, persistent fever, bleeding, or altered level of consciousness immediately and seek immediate medical attention.

ABD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some possible etiologies of abdominal pain.

STANDARDS:

1. Discuss various etiologies for abdominal pain, i.e., appendicitis, diverticulitis, pancreatitis, peritonitis, gastroenteritis, bowel obstruction, ruptured aneurysm, ectopic pregnancy, and inflammatory bowel disease, as appropriate.

ABD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Explain circumstances/examples that should prompt immediate medical attention.
3. Discuss the procedure for obtaining follow-up appointments.
4. Emphasize that appointments should be kept.

ABD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about abdominal pain.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding abdominal pain.
2. Discuss the content of the patient information literature with the patient/family.

ABD-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and proper use of medication.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Emphasize the importance of maintaining strict adherence to the medication regimen.
3. Encourage the patient to carry a list of current medications.

ABD-N NUTRITION

OUTCOME: The patient/family will have an understanding of how nutrition might affect abdominal pain.

STANDARDS:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Review this list of foods.

ABD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the management of abdominal pain.

STANDARD:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Explain that pain medications should be utilized judiciously to prevent the masking of complications.
3. Advise the patient to notify the nurse or provider if pain is not adequately controlled or if there is a sudden change in the nature of the pain.
4. Caution the patient to take pain medications as prescribed, and not to take over-the-counter medications in conjunction with prescribed medications without the recommendation of the provider.
5. Explain that short term use of narcotics may be helpful in pain management as appropriate.
6. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
7. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
8. Explain non-pharmacologic measures that may be helpful with pain control.

ABD-TE TESTS

OUTCOME: The patient/family will have an understanding of tests to be performed, the potential risks, expected benefits and the risk of non-testing.

STANDARDS:

1. Explain that diagnostic testing may be required to determine the etiology of the pain so appropriate therapy can be initiated.
2. Explain the tests that have been ordered.
3. Explain the necessary benefits and risks of the tests to be performed. Explain the potential risk of refusal of the recommended test(s).
4. Inform the patient of any advance preparation for the test, i.e., nothing by mouth, enemas, etc.

ABD-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the possible treatments that may be prescribed including the risk and benefits of the treatments or the risk of non-treatment

STANDARDS:

1. List the possible therap(ies) that may be indicated for the treatment of abdominal pain.
2. Briefly explain each of the possible treatment options. Discuss the risk(s) and benefit(s) of the proposed treatment(s).
3. Explain the risk(s) of non-treatment of abdominal pain.

ADV-I INFORMATION

OUTCOME: The patient/family will understand that an Advance Directive is either a Living Will or a Durable Power of Attorney for Health Care.

STANDARDS:

1. Explain that an Advance Directive is a written statement that is completed by the patient in advance of serious illness, regarding how he/she wants medical decisions to be made.
2. Discuss the two most common forms of Advance Directives
 - a. Living Will
 - b. Durable Power of Attorney for Health Care.
3. Explain that a patient may have both a living will and a durable power of attorney for health care.

ADV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive and understand the contents of literature regarding Advance Directives.

STANDARDS:

1. Provide the patient/family with patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

ADV-LW LIVING WILL

OUTCOME: The patient/family will understand that a Living Will is a document that states the type of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself and is revocable.

STANDARDS:

1. Explain that a Living Will is a document that generally states the kind of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself.
2. Explain that the Living Will may be changed or revoked at any time the patient wishes.
3. Explain that the Living Will is a legal document and a current copy should be given to the health care provider who cares for the patient.

ADV-POA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

OUTCOME: The patient/family will understand that a Durable Power of Attorney for Health Care is a document that names another person as proxy for health care decisions and is revocable.

STANDARDS:

1. Explain that in most states, a Durable Power of Attorney for Health Care is a signed, dated, witnessed document naming another person, such as a husband, wife, adult child or friend as the agent or proxy to make medical decisions in the event that the patient is unable to make them for him/herself.
2. Explain that instructions can be included regarding **any** treatment/procedure that is wanted or not wanted, such as surgery, a respirator, resuscitative efforts or artificial feeding.
3. Explain that, if the patient changes his/her mind, the Durable Power of Attorney for Health Care can be changed in the same manner it was originated. Explain that a Durable Power of Attorney for Health Care may be prepared by an attorney, but this may not be required in some states.
4. Explain that a Durable Power of Attorney for Health Care pre-empts any other advance directive. Example: The Durable Power of Attorney for Health Care can authorize the person named in the document to make the decision to apply full resuscitation measures even in the presence of a living will if the patient is incapable of making a decision at the time.

ADV-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand their rights and responsibilities regarding Advance Directives.

STANDARDS:

1. Inform the patient of his/her right to accept, refuse, or withdraw from treatment, and the consequences of such actions.
2. Inform the patient of his/her right to formulate an Advance Directive and appoint a surrogate to make health care decisions on his/her behalf.
3. Explain that an Advance Directive may be changed or canceled by the patient at any time. Any changes should be written, signed and dated in accordance with state law, and copies should be given to the physician and others who received the original document.
4. Explain that it is the patient's responsibility to give a copy of the Advance Directive to the proxy, the health care provider, and to keep a copy in a safe place.

AN-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the complications of untreated anemia.

STANDARDS:

1. Explain that failure to adhere to prescribed therapy will result in a chronic lack of oxygen, possibly producing signs and symptoms such as chronic or severe fatigue, chronic dyspnea, inability to concentrate, irritability, depression, anxiety, tachycardia and susceptibility to infection.
2. Explain that if tissues don't receive enough oxygen, the body will compensate by increasing heart rate and cardiac output.

AN-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of anemia, the specific cause of the patient's anemia and its symptoms.

STANDARDS:

1. Explain that anemia describes a condition in which the concentration of hemoglobin is too low. This may be the result of decreased number of red blood cells, abnormal red blood cells, abnormal hemoglobin molecules or deficiency of iron or other essential chemicals.
2. Explain that the kidneys, bone marrow, hormones and nutrients within the body work in cooperation to maintain the normal red blood cell count.
3. Explain that there are several categories of abnormal conditions that cause anemia. (Discuss those that pertain to this patient)
 - a. Lack of dietary iron, vitamin B12 or folic acid
 - b. Hereditary disorders of the red blood cells, such as Sickle Cell Anemia or thalassemia
 - c. Disorders involving the bone marrow or spleen which inhibit red blood cell formation or destroy red blood cells
 - d. Blood loss from the GI tract or other organ as a result of disease or trauma
 - e. Kidney disease which may result in decreased production of red blood cells
 - f. Thyroid or other hormonal diseases
 - g. Cancer and/or the treatment of cancer
 - h. Medications
 - i. Anemia of chronic disease
4. Explain that when the body's demand for nutrients, including iron, vitamin B12 or folic acid, isn't met, the body's reserves can be rapidly depleted and the nutrients will not be available to produce red blood cells. Fewer circulating red blood cells cause both hemoglobin concentration and the blood's oxygen-carrying capacity to decrease. Consequently, the patient may develop signs and symptoms of anemia.
5. Explain that the body's demand for iron will increase after blood loss, with certain medications and at certain life stages, such as infancy, adolescence and in women during pregnancy.
6. Explain that symptoms of anemia may include fatigue, headache, lightheadedness, tachycardia, anxiety, depression, exertional dyspnea and angina.

AN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage their anemia and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and adherence to it are the responsibility of the patient.
2. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.

AN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding the specific type of anemia and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the specific type of anemia and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

AN-M MEDICATIONS

OUTCOME: The patient will have an understanding of the importance of their prescribed medications and adherence to the medication treatment plan.

STANDARDS:

1. Explain that iron replacement therapy is necessary to correct iron-deficiency anemia and oral iron is prescribed most often. It is the safest and most effective treatment. Discuss that iron should be taken as prescribed. Explain that an overdose of iron can be lethal. Emphasize the importance of keeping iron out of the reach of children.
2. Explain that iron injections, which are not as easy, safe or effective, may be necessary if oral iron is not tolerated.
3. Explain that in order to restore total body iron stores a minimum course of iron therapy of three months is usually indicated.
4. Instruct the patient not to take antacids, calcium supplements, dairy products, eggs, whole grain breads, tea or coffee, soy products or wine within 1 hour of taking oral iron. These substances as well as some others interfere with the absorption of iron.
5. Review the proper use, benefits, and common side effects of iron or any other medications prescribed to treat the specific anemia.
6. Review the clinical effects expected with these medications

AN-N NUTRITION

OUTCOME: The patient/family will have an understanding of the role dietary modification plays in treating anemia and develop an appropriate plan for the necessary dietary modifications.

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process if it includes insufficient iron, vitamins and protein to meet the body demands during stages of life when requirements are increased.
2. Explain that diet alone usually cannot treat anemia, but plays an important role in therapy.
3. Encourage the patient to include foods rich in protein, vitamins and iron in the diet.
4. Explain that ascorbic acid (vitamin C) helps the body absorb iron. Instruct the patient to eat plenty of fruits and vegetables and drink fruit juice in place of sodas. If vitamin C supplementation is desirable vitamin C and iron should be taken at the same time.
5. Explain that anorexia and sore mouth often accompany anemia. If this is a problem, suggest frequent, small meals of easily digested food and the avoidance of hot spicy foods.
6. Discuss that pica (the ingestion of dirt or other non-food substances) may be both a symptom and a cause of anemia.

AN-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

AN-TE TESTS

OUTCOME: The patient/family will have an understanding of the possible tests that may be performed.

STANDARDS:

1. Explain that blood test(s) (i.e., hemoglobin, hematocrit, iron studies, hemoglobin electrophoresis) in conjunction with a thorough history and physical exam are necessary to diagnose anemia.
2. Explain that further tests, including a bone marrow exam, may be necessary to determine the type and cause of the anemia.
3. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
4. Explain that a complete blood count will be necessary to evaluate hemoglobin levels and detect physical/chemical changes in red blood cells or hemoglobin molecules.
5. Explain that periodically during treatment, blood counts must be obtained to assess the patient's degree of recovery.

AN-TX TREATMENTS

OUTCOME: The patient/family will have an understanding of the possible treatments that may be performed based on the test results.

STANDARDS:

1. Explain that treatment for anemia depends on the cause and severity.
2. Explain that a treatment plan including a diet of iron-rich foods and iron replacement is necessary to treat iron-deficiency anemia and B12 injections treat pernicious anemia. Other anemias are treated by treating the specific cause of the anemia.
3. Explain that the treatment of severe anemia may include transfusions of red blood cells.
4. Explain that once the hemoglobin levels return to normal, therapy for iron-deficiency anemia should continue for at least 2 months to replenish the body's depleted iron stores.
5. Explain that some anemias require long-term or lifelong treatment and others may not be treatable.

ANS - C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of anesthesia and symptoms that should be reported.

STANDARDS:

1. Discuss the common and important complications of anesthesia, i.e., potential for death, disability, drug reaction, pain, nausea and vomiting, disorientation, as appropriate.
2. Advise the patient/family to report any unexpected symptoms, i.e., shortness of breath, dizziness, nausea, chest pain, numbness.

ANS-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate when appropriate, the use of equipment to be used post-operatively. The patient/family will further understand as appropriate, equipment to be used during anesthesia.

STANDARDS:

1. Discuss the equipment to be used during anesthesia, including monitoring and treatment devices.
2. Discuss the function and use of any equipment that will be used postoperatively for monitoring or continued analgesia, i.e., cardiac and apnea monitors, pulse oximeter, and PCA pumps as appropriate.

ANS - FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up care and plan to keep appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Discuss indications for returning to see the provider prior to the scheduled appointment.

ANS-INT INTUBATION

OUTCOME: The patient/family will verbalize basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

ANS - L LITERATURE

OUTCOME: The patient/family will receive written information about anesthesia.

STANDARDS:

1. Provide the patient/family with written information about anesthesia or anesthetics.
2. Discuss the content of the patient literature with the patient/family.

ANS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

ANS - PO POSTOPERATIVE

OUTCOME: The patient/family will understand some post-anesthesia sequelae.

STANDARDS:

1. Review expected post-operative course with the patient/family.
2. Discuss with the patient/family common or important post-anesthetic side effects.
3. Explain some causes of post-anesthetic side effects and what courses of action might be required.

ANS-PR PREOPERATIVE

OUTCOME: The patient and family will be prepared for the specific type of anesthetic to be used during a procedure or surgery.

STANDARDS:

1. Explain pre-anesthetic preparation, including NPO (nothing by mouth) requirements and the medication(s) to take prior to the procedure.
2. Explain the type of anesthetic that is medically suggested. Discuss risks and benefits to the patient and unborn infant if applicable.
3. Explain alternative type(s) of anesthetic as appropriate.
4. Discuss common and important complications of anesthesia.
5. Discuss the role of the anesthetic care provider during a surgical/procedure case.
6. Explain the effects of anesthesia on the patient after the procedure is completed.

BL-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the potential complications of blood transfusions and the potential complications that might result from withholding blood transfusion.

STANDARDS:

1. Explain that there are two potential major complications from blood transfusions that occasionally occur.
 - a. Explain that the patient may develop volume overload as a result of the blood transfusion, particularly if the patient is a neonate, elderly, or has cardiopulmonary disease. The symptoms which should be reported to the nurse immediately may include:
 - i. restlessness
 - ii. headache
 - iii. shortness of breath
 - iv. wheezing
 - v. cough
 - vi. cyanosis
 - b. Explain that a transfusion reaction may occur. Explain that transfusion reactions may be severe and can include anaphylaxis or death. Instruct the patient/family that the following symptoms should be reported to the nurse immediately. Discuss that the symptoms are usually mild and may include:
 - i. hives
 - ii. itching
 - iii. rashes
 - iv. fever
 - v. chills
 - vi. muscle aches
 - vii. back pain
 - viii. chest pain
 - ix. headaches
 - x. warmth in the vein
2. Explain that blood supplies are currently thoroughly tested for blood borne diseases such as HIV or hepatitis. There still remains a small risk of transmission of blood borne disease from transfusion of blood or blood components.

BL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

BL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about blood transfusions.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding blood transfusions.
2. Discuss the content of the patient information literature with the patient/family.

BL-S SAFETY

OUTCOME: The patient/family will have an understanding of the precautions taken to ensure that blood transfusions are safe and provide minimal risk for disease transmission or increased health risk.

STANDARDS:

1. Explain that blood collecting agencies make every effort to assure that the blood collected for donation is safe.
2. Explain that blood donors are carefully screened through a medical and social history before they donate blood.
3. Explain that donated blood is thoroughly tested to make sure it is free from disease or infection.
4. Explain that the laboratory carefully tests donated blood and the patient's blood to make sure that they are compatible.
5. Explain that two nurses will check to verify that the transfusion is intended for the patient and that it has been properly tested for compatibility.
6. Explain that the patient will be closely monitored by the nursing staff during the transfusion so that any complications or reactions will be identified and treated immediately.
7. Explain that it is the responsibility of the patient/family to report any suspected reactions immediately.

BL-TX**TREATMENT**

OUTCOME: The patient/family will have an understanding of the necessity for the blood transfusion.

STANDARDS:

1. Explain that a blood transfusion is the transference of blood from one person to another.
2. Explain that blood transfusions are necessary to treat blood losses related to surgery or trauma, to treat blood disorders, or treat cancer or leukemia. Identify the specific reason that the patient requires a transfusion.
3. Explain that there are a variety of blood components available. Describe the blood component that will be administered and explain the necessity as related to the specific injury or disease process.

CA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and family will have a basic understanding of the normal function of organ(s)/site being affected by the cancer.

STANDARD:

1. Explain relationship of anatomy and physiology of the system involved and how it may be affected by this tumor.
2. Discuss changes in health of the patient as it relates to the cancer site and the potential impact on health and well being.

CA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand that both the disease process and the therapy may have complications which may or may not be treatable.

STANDARDS:

1. Explain that cancer, depending on the primary site, size of the tumor, or degree of metastasis, and specific treatment regimens have various and diverse complications.
2. Explain that many therapies for cancer depress the immune system and that infection is a major risk.
3. Discuss that many therapies for cancer will have as a side-effect nausea and vomiting. This can often be successfully medically managed.
4. Discuss that pain may be a complication of the disease process or the therapy.

Refer to [PM](#).

CA-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will have an understanding of the definition of cancer, and types affecting American Indian population and treatment options available to alleviate specific to the patient's diagnosis.

STANDARD:

1. State the definition of Cancer, the specific type, causative and risk factors and effect of primary site of the cancer and staging of the tumor.
2. Discuss signs and symptoms and usual progression of specific cancer diagnosis.
3. Discuss significant complications of treatment.
4. Explain that many cancers are curable and most are treatable. Discuss prognosis of specific cancer.
5. Discuss the importance of maintaining a positive mental attitude.

CA-EQ EQUIPMENT

OUTCOME: The patient and family will verbalize understanding of durable medical equipment and demonstrate proper use and care of equipment.

STANDARDS:

1. Discuss the indication for and benefits of prescribed home medical equipment.
2. Demonstrate the proper use and care of medical equipment.
3. Review proper function and demonstrate safe use of equipment.
4. Discuss infection control principles as appropriate.

CA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of adherence to treatment regimen and to maintain activities to follow up with outside referral sources.

STANDARDS:

1. Emphasize the importance of obtaining referrals for contract health services when appropriate.
2. Explain that test(s) required by private outside providers need coordination with Indian health physicians.
3. Discuss process for making follow up appointments with internal and external providers.
4. Discuss individual responsibility for seeking and obtaining third party resources.
5. Discuss the importance of keeping follow-up appointments and how this may affect outcome.

CA-HM HOME MANAGEMENT

OUTCOME: The patient and family will understand home management of cancer process and develop a plan for implementation. The patient/family/caregiver will understand the coordination of health care services to assure the patient receives comprehensive care.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change on a day to day or week to week basis.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources as appropriate. Refer to hospice care as appropriate.
4. Refer to support groups as appropriate.

CA-L LITERATURE

OUTCOME: The patient/family/caregiver will receive written information of cancer and organizations that assist in the care of patients with cancer such as the American Cancer Society.

STANDARDS:

1. Provide written information about specific cancer diagnosis to the patient/family/caregiver.
2. Review content of patient information literature with patient/family/caregiver.
3. Advise of any agency or organization that can provide assistance and further education such as support groups.

CA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and family will attempt to make necessary lifestyle adaptations to prevent or delay the onset of complications or to improve overall quality of life.

STANDARDS:

1. Review lifestyle behaviors the patient has control over such as diet, exercise, and habits related to risk of disease.
2. Encourage adherence with treatment plan.
3. Emphasize importance of the patient adapting to a lower risk, healthier lifestyle.
4. Review community resources available to assist the patient making changes. Refer as appropriate.

CA-M MEDICATIONS

OUTCOME: The patient and family will understand choice of medication to be used in management of cancer disease.

STANDARDS:

1. Explain medication regimen to be implemented. **Refer to [PM](#).**
2. Explain medication to be used including dose, timing, adverse side effects including drug-food interactions.
3. Explain affects of chemotherapy such as hair loss, nausea, vomiting and altered immune status.
4. Caution on the administration of live vaccines to self and family as appropriate. Discuss the implications of immunization advantages and disadvantages.

CA-N NUTRITION

OUTCOME: The patient, family/caregiver will receive nutritional assessment and counseling. Patient will verbalize understanding of need for a well balanced nutritional plan.

STANDARDS:

1. Assess patient's current nutritional level and determine an appropriate meal plan.
2. Discuss ways the meal plan can be enhanced to decrease nausea and vomiting, or other complications associated with the therapy or the disease process.
3. Explain that medications may be provided to enhance appetite, decrease adverse effects of therapy or the disease process to assist in maintenance of proper nutrition.
4. Review normal nutrition needs for optimum health.
5. Discuss current nutritional habits and assist in developing a plan to implement the prescribed nutritional plan.
6. Discuss the patient's right to decline nutritional support.

CA-P PREVENTION

OUTCOME: The patient and family will have awareness of risk factors associated with the development of cancer and be able to access health activities.

STANDARDS:

1. Explain that the use of tobacco is a major risk factor for many and diverse types of cancer.
2. Discuss the need to use sunscreens or reduce sun exposure.
3. Discuss reduction to exposure of chemicals as appropriate.
4. Discuss other preventive strategies as currently determined by the American Cancer Society.
5. Discuss the importance of health surveillance and routine health maintenance and recommended screening procedures for a patient of this age/sex (PAP smears, colonoscopy, BSE, TSE, PSA, etc.).
6. Emphasize the importance of early detection of cancer in cancer cure. Encourage the patient to come in early if signs of cancer (unexpected weight loss, fatigue, GI bleeding, new lumps or bumps, nagging cough or hoarseness, change in bowel or bladder habits, changes in warts or moles, sores that don't heal, etc.) are detected.

CA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to [PM](#).**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain or nausea and vomiting.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CA-REF REFERRAL

OUTCOME: The patient/family will understand referral and contract health services process and will make a plan to follow-up with contract health services.

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., benefits coordinator, social services.
6. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only**, unless otherwise specified. Future and/or additional referrals must be approved prior to the appointment.

CA-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be performed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential risks associated with the alternatives, i.e., risk of non-testing.

STANDARDS:

1. Explain that tests may be necessary for diagnosis or staging of cancer and follow-up therapy. Discuss the procedure for the test to be performed, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives including the risk of non-testing.
3. Explain any preparation for testing that is necessary, i.e., NPO status, bowel preps.

CA-TX TREATMENT

OUTCOME: The patient/family will understand the difference between palliative and curative treatments; and understand that the focus of the treatment plan will be on the quality of life rather than quantity of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.
4. Explain that treatments may prolong the patient's life and improve the quality of life by increasing patient comfort or curing of the disease process.
5. Discuss therapies that may be utilized including chemotherapy, surgical debulking or removal of tumor and radiation therapy as appropriate.
6. Explain that various treatments have their own inherent risks, side effects and expected benefits. Explain the risk/benefit of treatment/non-treatment.

CPM-DP DISEASE PROCESS

OUTCOMES: The patient/family will understand the pathophysiology of the patient's specific condition.

STANDARDS:

1. Review the causative factors as appropriate to the patient. Assess the level of pain. Emphasize that the goal of treatment is to relieve pain.
2. Review lifestyle factors which may worsen or aggravate the condition.
3. Discuss the patient's specific condition, including anatomy and pathophysiology as appropriate.
4. Discuss that chronic pain is a multifaceted condition. Explain that control of contributing factors may help to control the pain, i.e., dysfunctional sleep patterns, depression or other psychological disorders, other disease states.

CPM-EX EXERCISE

OUTCOMES: The patient will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

1. Review the different types of exercise including active and passive range of motion and strengthening.
2. Explain the hazards of immobility. Discuss how to prevent contractures, constipation, isolation and loss of self-esteem.
3. Emphasize that physical activity/therapy is an integral part of the patient's daily routine.
4. Emphasize that moderate exercise may increase energy, control weight, improve circulation, enhance sleep, and reduce stress and depression.

CPM-FU FOLLOW-UP

OUTCOMES: The patient/family will understand the importance of follow-up and make a plan to make and keep the follow-up appointments.

STANDARDS:

1. Provide positive reinforcement for areas of achievement.
2. Emphasize the importance of follow-up care to prevent complications and adjustments of medication.
3. Encourage active participation in the treatment plan and acceptance of the diagnosis.
4. Explain the procedure for obtaining appointments.

CPM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about chronic pain.

STANDARDS:

1. Provide patient/family with written patient information literature on chronic pain.
2. Discuss the content of patient information literature with the patient/family.

CPM-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder.

STANDARDS:

1. Explain that the patient has a responsibility to make lifestyle adaptations to assist in controlling pain.
2. Assess the patient/family's level of acceptance of the disorder.
3. Emphasize the importance of rest and avoidance of fatigue.
4. Discuss the use of heat and cold as appropriate.
5. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or community resources as appropriate.
6. Review the areas that may require adaptations: diet, physical activity, sexual activity, and bladder/bowel habits.

CPM–M MEDICATIONS

OUTCOMES: The patient will understand the goal of medication therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug/drug or drug/food interactions of medications.
3. Discuss the importance of taking medications as prescribed.
4. Emphasize the importance of taking medications as prescribed. If more medication is needed consult with the medical provider prior to increasing the dose of medication.
5. Discuss non-pharmacologic pain control measures.

CPM–S SAFETY

OUTCOMES: The patient will understand the importance of injury prevention and safety.

STANDARDS:

1. Explain to patient/family the importance of body mechanics to avoid injury.
2. Assist the family in identifying ways to adapt the home to prevent injuries or improve safety (remove throw rugs, install bars in the tub/shower, etc.).
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair, etc.).

CRN-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of Crohn's disease and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of Crohn's disease are stricture and fistulae formation, hemorrhage, bowel perforation, mechanical intestinal obstruction, and colorectal cancer, etc.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., blood in the stool, unusual drainage, unusual abdominal pain, change in frequency of stools, fever.

CRN-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their Crohn's disease.

STANDARDS:

1. Explain that Crohn's disease is a chronic inflammatory disease of the small intestine, usually affecting the terminal ileum at the region just before the ileum joins the colon. The etiology is unknown.
2. Explain that there is a familial tendency toward Crohn's disease and it occurs mostly in those between 15 and 35 years of age.
3. Explain that this condition interferes with the ability of the intestine to transport the contents of the upper intestine through the constricted lumen, causing crampy pains after meals.
4. Explain that chronic diarrhea due to the irritating discharge from the intestine occurs and may be accompanied by bloody stools.
5. Explain that in some patients, the inflamed intestine may perforate and form intra-abdominal and anal abscesses.
6. Explain that this condition is characterized by exacerbations and remissions that may be abrupt or insidious.

CRN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

CRN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the Crohn's disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding Crohn's disease.
2. Discuss the content of the patient information literature with the patient/family.

CRN-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

CRN-N NUTRITION

OUTCOME: The patient/family will have an understanding of how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Instruct the patient/family to abstain from fresh fruits, fresh vegetables and dairy products and eat foods that are low in fats. Provide a list of foods for the patient to avoid, if available.
3. Assist the patient/family in developing appropriate meal plans.
4. Explain to the patient/family that parenteral hyperalimentation may be necessary to maintain nutrition while allowing the bowel to rest.
5. Refer to dietitian as appropriate.

CRN-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

CRN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Advise the patient/family to strictly follow dietary guidelines to assist in the control of crampy pain after meals.
2. Advise the patient to comply with medication regimen to decrease the inflammation and pain.
3. Instruct the patient in meticulous anal skin care with protective creams to prevent skin breakdown and pain.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

CRN-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed. The patient/family will further understand the risk/benefit ratio of the proposed testing, alternatives to testing and risks of non-testing.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
 - a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
 - b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Upper gastrointestinal barium studies.
 - a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
 - b. Explain that barium liquid will be swallowed and radiographs taken.
3. Barium Enema
 - a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
 - b. Explain that barium liquid will be introduced by enema and radiographs taken.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
4. Discuss the risk/benefit ratio of testing, alternatives to testing and the risk of non-testing.

CRN-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the appropriate treatment for bowel disease and verbalize a plan to adhere to the treatment regimen. The patient/family will further understand the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. A diet restricted to no fruits or vegetables, low in fats and free of dairy products.
 - b. Parenteral hyperalimentation to maintain nutrition while allowing the bowel to rest.
 - c. Corticosteroids, salicylates, and/or other anti-inflammatory agents to decrease inflammation.
 - d. Medications to control diarrhea.
 - e. Rest.
 - f. Surgery to correct hemorrhage, fistulas, bowel perforation or intestinal obstruction.
2. Discuss the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand common or serious complications of uncontrolled blood sugar.

STANDARDS:

1. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
2. Emphasize that good control of blood sugar can dramatically reduce the risk of complications and end-organ damage.
3. State that Type 2 DM is a chronic disease that needs to be monitored for complications. Routine examinations are essential.
4. Discuss common complications of uncontrolled high blood sugar (blindness, impotence, increased yeast infections, increased urinary tract infections, kidney failure, loss of limbs, heart attack, stroke, early death, etc.).
5. Explain that patients with Type 2 DM are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate.
6. Explain that patients with Type 2 DM are at high risk for visual loss. Review the current recommendations for eye examinations and refer to appropriate health-care providers.
7. Explain that uncontrolled blood sugar can result in small-vessel damage in the heart which leads to heart attacks and cannot usually be treated. Explain that Type 2 DM also worsens atherosclerotic disease which can also lead to heart attacks and strokes.

DM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of Type 2 DM.

STANDARDS:

1. Briefly describe the pathophysiology of Type 2 DM, including the concept of insulin resistance.
2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Describe risk factors for development and progression of Type 2 DM (family history, obesity, high intake of simple carbohydrates, sedentary lifestyle, etc.).
4. Describe feelings/symptoms which the patient may experience when blood sugar is high (increased thirst, increased urination, lethargy, headache, blurry vision, impaired concentration, etc.).
5. Emphasize that Type 2 DM is a chronic, controllable condition which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to [DM-LA](#).**

DM-EQ EQUIPMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home glucose monitoring and/or home blood pressure monitoring and/or home ketone monitoring and/or home insulin pumps.
2. Demonstrate and receive return demonstration of home glucose monitoring and/or the use of other home equipment.
3. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
4. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
5. Emphasize the importance of home blood pressure monitoring as appropriate.

DM-EX EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity in achieving and maintaining good blood sugar control and will make a plan to increase regular activity by and agreed-upon amount.

STANDARDS:

1. Explain that regular aerobic exercise will reduce the body's resistance to insulin.
2. Explain that the goal is at least 20-30 minutes of aerobic exercise (such as vigorous walking) at least 5 times per week. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan.
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.

DM-FTC FOOT CARE AND EXAMINATIONS

OUTCOME: The patient/family will understand the risks of skin breakdown, ulcers, and lower extremity amputation associated with Type 2 DM and develop a plan for blood sugar control and regular foot care to prevent these complications.

STANDARDS:

1. Emphasize that even a minor injury to the foot can result in amputation. Stress that wounds do not heal properly if blood sugar is elevated.
2. Demonstrate the proper technique for a daily home foot check by patient or support person.
3. Discuss "dos and don'ts" of diabetic foot care (don't go barefoot, wear appropriate footwear, don't trim you own nails, etc.).
4. Discuss the relationship between peripheral vascular disease, neuropathy, and high blood sugar. Explain that the progression to amputation is typical without early and appropriate intervention.
5. Emphasize the importance of footwear which is properly fitted for patient with diabetes. Refer for professional evaluation and fitting as appropriate.
6. Remind the patient to remove shoes for each clinic visit.
7. Emphasize the importance of a regularly scheduled detailed foot exam by a trained health care provider.

DM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications and progression and will develop a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of early intervention to prevent complications.
2. Explain that since blood sugar control is critical, regular medical appointments are necessary to adjust treatment plans and prevent complications.
3. Explain that the home glucose monitoring log is an essential part of formulating the treatment plan and must be brought to every appointment.
4. Explain that since Type 2 DM is a chronic condition which affects the entire body, total care is essential. Emphasize the importance of keeping appointments with all health care providers (dental, eye care, foot care, laboratory, etc.).
5. Discuss the procedure for making appointments.

DM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home management (nutrition, exercise, home glucose monitoring, self-administration of insulin, taking medications, etc.).
2. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.
3. Describe proper storage, care and disposal of medicine and supplies.
4. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
5. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
6. Emphasize the importance of daily foot checks and appropriate foot care. **Refer to [DM-FTC](#).**
7. Emphasize the importance of good personal and oral hygiene.
8. Emphasize the importance of nutritional management. Refer to dietician or other local resources as appropriate.

DM-KID KIDNEY DISEASE

OUTCOME: The patient/family will understand the risks of kidney damage and end-stage renal disease resulting in dialysis associated with Type 2 DM and develop a plan for blood sugar control and regular medical examinations to prevent these complications.

STANDARDS:

1. Emphasize that high blood sugar results in damage to the kidneys. This may result in renal failure requiring long term dialysis or kidney transplant. Once kidney damage occurs it cannot be reversed.
2. Emphasize the need for regular urine analysis and blood chemistry screening.
3. Emphasize that high blood pressure worsens diabetic kidney disease. Reinforce the importance of regular blood pressure screening and taking antihypertensive medications as prescribed. **Refer to [HTN](#).**

DM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Type 2 DM.

STANDARDS:

1. Provide the patient/family with written patient information on Type 2 DM.
2. Discuss the content of the patient information with the patient/family.

DM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that the most important component in control of high blood sugar is the patient's lifestyle adaptations and will develop a plan to achieve optimal blood sugar control.

STANDARDS:

1. Emphasize that diet and exercise are the critical components of blood sugar control and medical therapies can at best supplement diet and exercise.
2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Explain that the longer the blood sugar is elevated, the greater the damage will be.
4. State the reasons for blood glucose monitoring – to keep track of the level of blood sugar and permit rapid changes necessary to keep sugar under control.

DM-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen.

STANDARDS:

1. Explain that diet and exercise are the key components of control of Type 2 DM and that medication(s) may be prescribed as a supplement to diet and exercise.
2. Describe the proper use, benefits, and common or important side effects of the patient's medication(s). State the name, dose, and time to take pills and/or insulin.
3. For patients on insulin, demonstrate steps in insulin administration. Describe proper storage, care and disposal of medicine and supplies.
4. Reinforce the need to take insulin and other medications when sick and during other times of stress.
5. Emphasize the importance of strict adherence to the medication regimen. Explain that many medications for Type 2 DM do not exert an immediate effect and must be used regularly to be effective.
6. Briefly explain the mechanism of action of the patient's medications as appropriate.
7. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
8. Discuss the signs, symptoms and appropriate actions for hypoglycemia.

DM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of blood sugar and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and responsible eating.
2. Review the food pyramid and its role in meal planning. Refer to dietician or other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods (broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease, etc.).
5. Emphasize the importance of appropriate serving sizes.
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that complex carbohydrates and low-fat proteins are preferred and that sugars and fats should be limited.

DM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of Type 2 DM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the role of obesity in the development of Type 2 DM.
2. Emphasize that to maintain health and prevent diabetes, extra commitment is necessary for people with a family and/or gestational history of Type 2 DM.
3. Explain that following the food guide pyramid and maintaining adequate activity levels will reduce the risk of getting Type 2 DM.
4. Explain that many people have Type 2 DM for as much as 5-7 years before diagnosis, and that end-organ damage is occurring during that time. Emphasize the importance of regular screening. Discuss current recommendations for screening.
5. Explain that the child of a mother who had high blood sugar during pregnancy is at greatly increased risk for development of Type 2 DM. Emphasize that family planning, pre-conception screening, and early prenatal care can significantly reduce this risk.

DM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the importance of appropriate management of pain.

STANDARDS:

1. Explain that lower extremity pain may be significant for complications associated with neuropathy which needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

DM-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

DIV-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of diverticulosis and diverticulitis may include hemorrhage, abscess development and perforation with peritonitis, bowel obstruction, intussusception, and volvulus.
2. Advise the patient to seek immediate medical care for any signs of complications, such as lower abdominal cramping, abdominal distention fever, malaise, hemorrhage.

DIV-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of diverticulitis/diverticulosis.

STANDARDS:

1. Explain that a diverticulum is a pouch or saccular dilatation from the main bowel cavity. Diverticulosis is the condition in which an individual has multiple diverticulae. Diverticulitis is an inflammation of one or more diverticulae.
2. Explain that- some of the- predisposing factors may include congenital predisposition, weakening and degeneration of the muscular wall of the intestine, chronic over distention of the large bowel, and a diet low in roughage.
3. Explain that diverticulosis develops in nearly 50% of persons over age 60, but only a small percentage develops diverticulitis.
4. Explain that diverticulosis-ma-y be accompanied by minor bowel irregularity, constipation and diarrhea.
5. Explain that symptoms of diverticulitis may range from mild abdominal soreness and cramps with "gas" and low grade fever, to more severe cramping and pain accompanied by fever, chills, nausea, abdominal rigidity and massive hemorrhage.
6. Inform the patient that diverticulitis may be acute or chronic.

DIV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

DIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about diverticulitis and or diverticulosis.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding diverticulitis and/or diverticulosis.
2. Discuss the content of the patient information literature with the patient/family.

DIV-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and make a plan to take the medication as prescribed.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed (when indicated.)
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

DIV-N NUTRITION

OUTCOME: The patient/family will have an understanding of how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Emphasize the hazards of constipation.
3. Explain that during periods of acute inflammation, it may be necessary to begin with a very restricted diet and slowly progress to a bland diet.
4. Explain that bulk can be added to stools by eating fruits and vegetables with a high fiber content (seedless grapes, fresh peaches, carrots, lettuce.)
5. Encourage a diet that is high in fiber and low in sugar to maintain intestinal tract function. Advise to avoid indigestible roughage, such as celery and corn.
6. Provide list of appropriate foods that are high in fiber and low in sugar.
7. Advise the patient/family to avoid extremely hot or cold foods and fluids, because they may cause flatulence. Also, alcohol, which irritates the bowel, should be avoided. Stress the importance of thoroughly chewing all foods.
8. Assist the patient/family in developing appropriate meal plans.
9. Stress the importance of water in maintaining fluid balance and preventing constipation.
10. Refer to dietitian as appropriate.

DIV-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of diverticulitis and/or diverticulosis.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

DIV-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that diverticulitis with pain usually responds to a liquid or bland diet and stool softeners to relieve symptoms, minimize irritation, and decrease the spread of the inflammation.
2. Discuss the plan for pain management during the acute phase, which may include opiate or non-opiate analgesics and anticholinergic to decrease colon spasms.
3. Advise the patient not to use over the counter pain medications without checking with his/her provider.
4. Discuss non-pharmacologic methods of pain control as appropriate.

DIV-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
 - a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
 - b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Barium Enema
 - a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
 - b. Explain that barium liquid will be introduced by enema and radiographs taken.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

DIV-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the prescribed treatment for diverticulitis/diverticulosis and verbalize a plan to adhere to the treatment regimen.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. During acute episodes, nothing by mouth and IV fluid and nutritional support may be necessary in order to rest the bowel
 - b. Liquid or bland diet during the less acute phase, then a high fiber diet to counteract the tendency toward constipation
 - c. Stool softeners
 - d. Antimicrobial therapy to combat infection
 - e. Antispasmodics to control smooth muscle spasms
 - f. Surgical resection of the area of involved colon and sometimes temporary colostomy
2. Advise the patient to avoid activities that raise intra-abdominal pressure, such as straining during defecation, lifting, coughing, etc.
3. Discourage smoking, as it irritates the intestinal mucosa.

DYS-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported immediately, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications of the particular dysrhythmia, e.g. angina, stroke, CHF.
2. List the symptoms that should be reported immediately, i.e., shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.
3. Discuss anticoagulant therapy if appropriate.

DYS-DP DISEASE PROCESS

OUTCOME: The patient will understand what the dysrhythmia is and the signs of the dysrhythmia.

STANDARDS:

1. Review the anatomy and physiology of the heart in relation to the patient's dysrhythmia.
 - a. Relate how the dysrhythmia occurs.
 - b. Describe the symptoms of the dysrhythmia.
 - c. List the symptoms that should be reported immediately, i.e., shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.

DYS-EQ EQUIPMENT

OUTCOME: The patient/family will understand the proper use and care of home medical equipment.

STANDARDS:

1. Emphasize the importance of following the prescribed check up and maintenance schedule for implanted or other home equipment.
2. Explain any limitations imposed by the equipment, i.e., exposure to magnetic fields, MRIs, microwaves, etc.

DYS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of the dysrhythmia.
2. Explain the procedure for making follow-up appointments.
3. Review the treatment plan with the patient, emphasizing the need for keeping appointments and medication adherence.

DYS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dysrhythmia.

STANDARDS:

1. Provide patient/family with written patient information literature on dysrhythmia.
2. Discuss the content of patient information literature with the patient/family.

DYS-M MEDICATIONS

OUTCOME: The patient will verbalize and understand the type of medication being used, the prescribed dosage and administration of the medication and will verbalize an understanding of the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication(s).
2. Emphasize the importance of maintaining strict adherence to the medication regimen and monitoring schedule.
3. Emphasize the importance of possible drug interactions with foods, drugs and over the counter medications.

DYS-TE TESTS

OUTCOME: The patient will have an understanding of the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered (ECG, echo, treadmill, electrophysiological mapping, etc.).
2. Explain the indications, risks, and benefits of the test(s).
3. Explain the test as it relates to planning the course of treatment.

DYS-TX TREATMENT

OUTCOME: The patient/family will understand the therapy and the goal(s) of treatment.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of the medications, side effects, signs of toxicity, and drug interactions.
2. Emphasize the importance of maintaining strict adherence to the medication regimen.
3. Explain other treatment options as appropriate (synchronized cardioversion, transcutaneous pacemaker, transvenous pacemaker, or permanent pacemaker).

F-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of fever.

STANDARDS:

1. Explain that most fevers are harmless and are the body's natural response to infection and that fever may even be helpful in fighting infection.
2. Explain that fevers below 107°F (41.6°C) do not typically cause any type of permanent damage. Explain that the brain's thermostat keeps untreated fever below this level.
3. Discuss that only about 5% of children who develop fever may have a brief seizure associated with the fever. Explain that this type of seizure is generally harmless and will usually go away as the child gets older. Seizures with fever in adults are not febrile seizures and may require further investigation.
4. Discuss the potentially fatal complications of fever in a child under 2 months of age.

F-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the role of fever in illness.

STANDARDS:

1. Discuss that fever is a body temperature that is above normal. Discuss the parameters used by your institution to define significant fever, i.e., rectal or oral temperature >101°F or >38°C.
2. Discuss that fever is a symptom, not a disease.
3. Discuss that fever is the body's natural response to infection.
4. Explain that fever helps fight infections by turning on the body's immune system and impeding the spread of the infection.
5. Explain that the height of the fever does not necessarily correspond to the seriousness of the illness. Explain that a better indicator of seriousness of illness is how sick the child or adult acts.
6. Discuss that most fevers are caused by viral illnesses, some are caused by bacterial illnesses. Explain that viral illnesses do not respond to antibiotic therapy.

F-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up for fever.

STANDARDS:

1. Explain the importance of returning to the clinic or emergency room immediately if the patient should become more ill, become lethargic, look very sick or develop a purple rash.
2. Discuss that if the patient does not seem to be getting better after a few days of treatment the patient may need to be re-evaluated.
3. Discuss the need to return to the clinic or emergency room for fever that will not come down with antipyretics (acetaminophen, ibuprofen, etc.) or is over 105° F (40.5°C).
4. Discuss the potentially fatal complications of fever in a child under 2 months of age. Explain that any child with a fever who is under 2 months of age should be seen by a physician immediately.

F-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home care techniques for responding to fever, as appropriate to this patient.

STANDARDS:

1. Explain that fever causes excess loss of body fluids because of sweating, increased heart rate and increased respiratory rate. Discuss the importance of extra fluids to replace this excess body fluid loss.
2. Explain that clothing should be kept to a minimum as most body heat is lost through the skin. Bundling will cause higher fever.
3. Discuss that sponging is not usually necessary to reduce fever.
 - a. Explain that sponging without giving acetaminophen or ibuprofen may cause shivering and this may actually increase the fever.
 - b. Instruct that if shivering occurs during sponging that the sponging should be discontinued to allow the fever reducing agent to work.
 - c. Discuss that if sponging is done, only lukewarm water should be used. Since sponging works to lower the temperature by evaporation of water from the skin's surface, sponging is more effective than immersion.
 - d. Explain that only water should be used for sponging.
4. Explain that the use of rubbing alcohol for sponging may cause the fumes to be breathed in and could cause coma.

F-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about fever.

STANDARDS:

1. Provide the patient/family with written patient information literature on fever.
2. Discuss the content of the patient information literature with the patient/family.
3. Explain the need for follow-up if the fever lasts for more than 3 days.

F-M MEDICATIONS

OUTCOME: The patient/family will understand the use of antipyretics in the control of fever.

STANDARDS:

1. Emphasize that aspirin (even baby aspirin) should NEVER be used to control fever in children under the age of 13 except under the direction of a physician.
2. Discuss the appropriate dose of acetaminophen for this patient. Discuss that acetaminophen may be given every 4-6 hours for the control of fever.
3. Discuss the appropriate dose of ibuprofen for this patient. Discuss that ibuprofen may be given every 6-8 hours for the control of fever.
4. As appropriate, discuss dosing of other fever reducing agents that may be used for this patient.
5. Discuss avoidance of combination products (antipyretics combined with decongestants, etc) unless directed to do so by a provider.
6. Discuss the method for combining acetaminophen and ibuprofen for the control of fever if appropriate. (Alternate the two medicines, i.e., acetaminophen every 8 hours and ibuprofen every 8 hours, giving one then the other at 4 hour intervals.)

FRST-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of frostbite; and the complications associated with frostbite.

STANDARDS:

1. Explain that the severity of frostbite is associated with how deep the freeze is. No tissue is safe. This can involve the skin layers as well as the fat, muscle, blood vessels, lymphatics, nerves and even the bones.
2. Discuss that frostbite is just like receiving a burn; and is categorized based upon the extent of the tissue injury.
 - a. First Degree: is a partial freeze of the skin. Clinical Appearance: Redness, swelling, possible peeling of skin about a week later. Symptoms: Periodic burning, stinging, aching, throbbing; excessive sweating in the area.
 - b. Second Degree: All layers of the skin have frozen. Clinical Appearance: Redness, significant swelling, blisters, black scabs, Symptoms: Numbness, heaviness of the affected area.
 - c. Third Degree: Skin and subcutaneous tissues are completely frozen. Clinical Appearance: Purplish blisters (blood-filled), dusky blue skin discoloration, death of the skin. Symptoms: Loss of sensation, area feels like “wood”. Later on, the area has significant burning and throbbing.
 - d. Fourth Degree: Complete involvement of skin, fat, muscle, bone. Clinical Appearance: Minimal swelling. The area is initially quite red, then becomes black. Symptoms: Occasional joint pain.
3. Emphasize the importance to avoid thawing and then refreezing the injury. This is very dangerous and can cause serious sequella.

FRST-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how frostbite occurs the signs and symptoms of frostbite, and risk factors associated with frostbite.

STANDARDS:

1. Explain that frostbite, simply defined, is the freezing of the skin and/or the bodily tissues under the skin.
2. Discuss signs and symptoms of frostbite with the patient/family:
 - a. Mild frostbite (frostnip) affects the outer skin layers and appears as a blanching or whitening of the skin.
 - b. Severe frostbite: the skin will appear waxy-looking with a white, grayish-yellow or grayish-blue color.
 - c. Affected body parts will have no feeling (numbness) and blisters may be present.
 - d. The tissue will feel frozen or “wooden”.
 - e. Other symptoms include swelling, itching, burning and deep pain as the area is warmed.
3. Discuss the pathophysiology of frostbite: the fluids in the body tissues and cellular spaces freeze and crystallize. This can cause damage to the blood vessels and result in blood clotting and lack of oxygen to the affected area.
4. Review with patient/family predisposing conditions to frostbite:
 - a. exposure of the body to cold
 - b. length of time a person is exposed to the cold
 - c. temperature outside
 - d. windchill factor
 - e. humidity in the air
 - f. wetness of clothing and shoes
 - g. ingestion of alcohol and other drug
 - h. high altitudes
5. Explain that frostbite can occur in a matter of minutes.
6. Discuss with patient/family that the most common parts of the body affected by frostbite include the hands, feet, ears, nose and face.
7. Review with patient/family the medical conditions that make some at greater risk for frostbite:
 - a. the elderly and young
 - b. persons with circulation problems

- c. history of previous cold injuries
- d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
- e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of frostbite and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after frostbite to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

FRST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about frostbite, and important preventive measures.

STANDARDS:

1. Provide patient and family with written information on frostbite and prevention of frostbite.
2. Discuss the content of frostbite written information with the patient and family.

FRST-M MEDICATIONS

OUTCOME: The patient and family will understand the use of medications to manage frostbite.

STANDARDS:

1. Explain to patient/family that the blistered areas may require topical medications applied during dressing changes as prescribed by provider.
2. Discuss appropriate medications available for acute and chronic pain.
3. Advise patient/family that a tetanus vaccination is necessary if not received in last 5-10 years.
4. Discuss the common and important side effects and drug interactions of medications prescribed.

FRST-N NUTRITION

OUTCOME: The patient/family will have an understanding of the nutritional problems associated with frostbite.

STANDARDS:

1. Discuss that based on severity of the injury the need for replenishment of calories, fluids, protein, nitrogen and other nutrients may be essential.
2. Refer to a dietician as appropriate.

FRST-P PREVENTION

OUTCOME: The patient and family will understand ways to prevent frostbite.

STANDARDS:

1. Discuss with the patient and family that the majority of frostbite cases are preventable, and that it is easier to prevent frostbite than to treat it.
2. Emphasize the importance of keeping clothing/socks dry. Wet clothing predisposes to frostbite.
3. Explain that it is important to minimize wind exposure. Wind proof clothing can be helpful. High winds increase heat loss from the body.
4. Discuss that it is important to wear loose, layered clothing (i.e., hat, gloves, loosely fitting layered clothing). Constrictive clothing increases the likelihood of frostbite as does immobilization and dependency of the extremities. Proper clothing for winter weather insulates from the cold, lets perspiration evaporate and provides protection against wind, rain and snow. Wear several layers of light, loose clothing that will trap air, yet provide adequate ventilation. This is better protection than one bulky or heavy covering.
5. Discuss the importance to stocking the vehicle appropriately for winter travel (i.e., blankets, gloves, hats).
6. Discuss that when in frostbite-causing conditions, dressing appropriately, staying near adequate shelter and remaining physically active can significantly reduce the risk of suffering from frostbite.
7. Discuss the importance of avoiding alcohol, and other drugs while participating in outdoor activities.
8. Review the sensations associated with overexposure to cold, i.e., sensations of intermittent stinging, burning, throbbing and aching are all early signs of frostbite. Get indoors.
9. Discuss with patient/family the medical conditions that make some at greater risk for frostbite:
 - a. the elderly and young
 - b. persons with circulation problems
 - c. history of previous cold injuries
 - d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
 - e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-PM PAIN MANAGEMENT

OUTCOME: The patient and family will understand how to manage the pain associated with the acute and chronic tissue damage caused from frostbite.

STANDARDS:

1. Discuss that there has been some evidence that aloe vera in a 70% concentration when applied topically may be helpful in pain management.
2. Discuss appropriate pain management plan with patient/family.

FRST-TX – TREATMENT

OUTCOME: The patient and/or family will have an understanding of the management and treatment of frostbite.

STANDARDS:

1. Discuss the goal of treatment with the patient; prevention of further exposure to affected area(s), and management and prevention of complications.
2. Emphasize the need to have frostbite injuries rewarmed under medical supervision.
3. Explain that the patient needs to get to a warm place where he/she can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
 - a. Use warm-to-the touch water 100° F (38° C.) For 30-45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
 - b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
 - c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
 - d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster (within 5-10 years).
6. Review treatment modalities that are not deemed appropriate methods to treat frostbite:
 - a. Don't use dry heat (sunlamp, radiator, heating pad) to thaw the injured area.
 - b. Don't thaw the injury in melted ice.
 - c. Don't rub the area with snow.
 - d. Don't use alcohol, nicotine or other drugs that may affect blood flow.

FRST-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.
6. Demonstrate the necessary wound care techniques.

GB-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the gallbladder is in the body and its function in digestion.

STANDARDS:

1. Discuss that the gallbladder is a small bag found under the liver.
2. Explain that the function of a normal gallbladder is to store bile, concentrate it by removing water and empty this concentrated bile into the intestine when fatty foods are eaten.
3. Explain that the gallbladder empties through the cystic duct into the common bile duct which then empties into the small intestine. Explain that the common bile duct also drains the liver and the pancreas.
4. Explain that the bile helps to digest the fat in the foods.

GB-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressed gallbladder disease. (Please choose from the following standards as they apply to this patient's specific disease process.)

STANDARDS:

1. Explain that if the amount of bile and other chemicals inside the gallbladder get out of balance gallstones can form. Most gallstones are cholesterol gallstones and form when too much cholesterol is secreted into the gallbladder from the liver.
2. Explain that gallstones usually don't cause a problem if they stay in the gallbladder. Approximately 80% of people with gallstones have no symptoms at all.
3. Explain that sometimes gallstones move into the ducts that drain the gallbladder and that this may lead to pain, infections, diseases of the liver, disease of the pancreas and may lead to gangrene or perforation of the gallbladder.
4. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death in about 25% of cases. Empyema is relatively rare, however, it does occur in about 2% of cases of acute cholecystitis.
5. Explain that patients with choledocholithiasis (stones in the common bile ducts) may get cholangitis (infection of the bile ducts). This is very serious and may be treated with antibiotics and may require surgery. Choledocholithiasis may also result in pancreatitis. **Refer to [PC](#).**
6. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

OUTCOME: The patient/family will verbalize understanding of the causes and symptoms of his/her gallbladder disease. (Please choose from the following standards as they apply to this particular patient.)

STANDARDS:

1. Explain that gallstones (cholelithiasis) can cause problems when a gallstone gets lodged in either the cystic duct or the common bile duct. This can result in right upper quadrant abdominal pain, nausea, vomiting, heartburn and back pain.
2. Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis. This condition is called choledocholithiasis.
3. Explain that biliary colic is a mild form of gallbladder disease and results in right upper quadrant abdominal pain several hours after eating a fatty meal. The pain is not relieved by changes in position, over-the-counter medications or passing gas. It will usually spontaneously resolve in 1-5 hours.
4. Explain that acute cholecystitis is similar to biliary colic but is more severe. It results from inflammation of the gallbladder. Infection is often present. The pain with cholecystitis is more severe and often patients complain of pain with breathing. This is a severe condition which can progress to perforation of the gallbladder or gangrene. Patients with acute cholecystitis should seek immediate medical attention.
5. Explain that chronic cholecystitis results from long term inflammation of the gallbladder with or without stones and results in scarring of the gallbladder. Patients with chronic cholecystitis will often have gas, nausea or abdominal discomfort after meals.
6. Explain that some drugs may induce gall bladder disease.
7. Explain that gallbladder disease is more common in the following groups of people:
 - a. Women
 - b. People over 40
 - c. Women who have been pregnant (especially women with multiple pregnancies)
 - d. People who are overweight
 - e. People who eat large amounts of dairy products, animal fats and fried foods, i.e., high fat diet
 - f. People who lose weight very rapidly
 - g. People with a family history of gallbladder disease
 - h. Native Americans (especially Pima Indians), Hispanics and people of Northern European descent
 - i. People with sickle-cell anemia, cirrhosis, hypertriglyceridemia (especially with low HDL cholesterol), or diabetes

GB-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to the treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gallbladder disease.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

GB-L LITERATURE

OUTCOME: The patient/family will receive written information about gallbladder disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gallbladder disease.
2. Discuss the content of patient information literature with the patient/family.

GB-M MEDICATIONS

OUTCOME: The patient/family will understand the medications to be used in the management of gallbladder disease.

STANDARDS:

1. Explain as indicated that some medications may be used to dissolve small gallstones.
2. Explain the regimen to be implemented in pain control as indicated.
3. Explain the medications to be used in this patient including the dosage, timing, proper use and storage of the medication, important and common side-effects of the medication including drug-drug and drug-food interactions.

GB-N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of ways diet relates to gallbladder disease.

STANDARDS:

1. Explain that a diet that is high in fat and simple sugars can contribute to the formation of gallstones.
2. Explain that rapid weight loss should be avoided as it may contribute to formation of gallstones. Encourage overweight persons to undertake a rational approach to weight loss that includes exercise and moderate dietary limitation under the consultation of a physician.

GB-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gallbladder disease.

STANDARDS:

1. Explain that maintaining a normal body weight and avoiding fasts are keys to reducing the risk of gallstones.
2. Explain that a low fat diet will help prevent gallbladder disease.
3. Explain that regular vigorous exercise reduces the risk of gallbladder disease. Exercises that seem most helpful are brisk walking, jogging, and racquet sports.

GB-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. Refer to [PM](#).

GB-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s) as well as risks, benefits and alternatives to the proposed procedure(s). **Refer to [SPE](#).**

STANDARDS:

1. Explain the specific procedure to be performed including the risks and benefits both of doing the procedure and adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure including expectant management, as appropriate.

GB-TE TESTS

OUTCOME: The patient/family will understand the proposed test(s) as well as risks, benefits and alternatives to the proposed test(s).

STANDARDS:

1. Explain the test to be performed including the potential benefit to the patient and any adverse effects of the test or adverse effects which might result from refusal of the test.
2. Explain the testing process to help the patient understand what he/she might experience during the test.
3. Explain any preparation the patient may need to do for the proposed test, i.e., NPO status.

GER-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of the anatomy and pathophysiology of gastroesophageal reflux disease.

STANDARDS:

1. Explain the anatomy and physiology of the esophagus and stomach.
2. Explain the process of acid reflux into the esophagus.
3. Explain how and why stomach acid reflux into the esophagus causes pain and disease.
4. Explain long-term complications of untreated GERD including carcinoma of the esophagus.

GER-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GER-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroesophageal reflux disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gastroesophageal reflux disease.
2. Discuss the content of the patient information literature with the patient/family.

GER-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family will understand how to control GERD through lifestyle adaptation.

STANDARDS:

1. Emphasize the importance of tobacco cessation and decreased alcohol consumption.
3. Identify obesity as a major exacerbating factor in GERD. Discuss the importance of regular exercise and its role in obtaining and maintaining desirable weight.
4. Identify foods that may aggravate GERD.
5. Review the effect of timing of meals, i.e., no large meals before bedtime, more frequent light meals instead of few large meals.
6. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOMES: Patient/family will verbalize an understanding of the medication, dosage and side effects that may occur. Patient/family will understand how the medication works to prevent the symptoms of GERD.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication..
2. Explain how the medication works to prevent the symptoms of GERD.
3. Explain that non-pharmacologic therapies in combination with medications will help reduce the symptoms of GERD.
4. Emphasize the importance of possible drug interactions with foods and over the counter medications.

GER-N NUTRITION

OUTCOME: The patient will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification as needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Gastroesophageal Reflux Disease.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

GER-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GER-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Upper gastrointestinal barium studies.
2. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
3. Explain that barium liquid will be swallowed and radiographs taken.
4. Discuss NPO status as indicated.
5. Discuss the test(s) for H. Pylori and how testing may assist in diagnosis and treatment.
6. Discuss as appropriate the procedure for EGD and the risks and benefits of performing this test. **Refer to [SPE](#).**

GER-TX TREATMENT

OUTCOME: The patient and/or family will have an understanding of the medical and surgical treatments available for GERD.

STANDARDS:

1. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
2. Discuss possible surgical interventions for GERD as appropriate.

GIB-C COMPLICATIONS

OUTCOME: The patient/family will understand the seriousness of gastrointestinal bleeding and will verbalize intent to obtain treatment if symptoms occur.

STANDARDS:

1. Explain that severe blood volume depletion and anemia can result from untreated gastrointestinal bleeding.
2. Explain that complications may be prevented with prompt treatment.
3. Discuss the symptoms of gastrointestinal bleeding, e.g. vomiting blood or coffee-ground emesis or black, tarry or bloody stools.

GIB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology and pathophysiology of their gastrointestinal disease.

STANDARDS:

1. Explain that gastrointestinal bleeding may have a variety of causes e.g. esophagitis, gastritis, peptic ulcers, esophageal varices, Crohn's disease, polyps, ulcerative colitis, diverticulosis or cancer.
2. Explain that the bleeding may present itself in a variety of ways, depending on the source and severity of the bleeding.
3. Explain that massive bleeding may result in weakness, dizziness, faintness, shortness of breath, crampy abdominal pain, diarrhea, or death.

GIB –FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up, care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GIB –L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process involved with the gastrointestinal bleeding.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the disease process involved with the gastrointestinal bleeding.
2. Discuss the content of the patient information literature with the patient/family.

GIB -M MEDICATIONS

OUTCOME: The patient will verbally summarize the prescribed medication regimen and the importance of adherence.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Discuss the use of antacids and medications to decrease acid production. Stress that absence of symptoms does not mean that the medication is no longer needed.
3. Stress the importance of avoiding substances containing aspirin, alcohol, nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate further bleeding.
4. Discuss the importance of adherence with the medication regimen in order to promote healing and assure optimal comfort.

GIB –N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of the prescribed diet.

STANDARDS:

1. Explain that rest of the gastrointestinal tract may be required in the immediate GI bleed period.
2. Explain that IV nutrition support may be necessary if prolonged abstinence from food is required.
3. Explain that certain foods are likely to exacerbate the GI condition and should be avoided, i.e., alcohol, caffeine, fatty foods
4. Explain that gradual introduction of oral nutrients will be accomplished while decreasing IV nutrition support. Bowel irregularity is common during this period of time.
5. Explain that bland starchy foods are easier to digest and may be more easily tolerated.
6. Discuss that consumption of yogurt (with live or active cultures) is often helpful to resume normal bowel flora.

GIB –P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gastrointestinal bleeding episodes.

STANDARDS:

1. Stress the importance of avoiding substances containing aspirin, alcohol nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate bleeding.
2. Emphasize the importance of bowel regular bowel movements in the prevention of GI bleeds.

GIB-TE TESTS

OUTCOME: The patient/family will have an understanding of the diagnostic tests to be performed, the risk(s) and benefits of the proposed test as well as the risk(s) of non-performance of the test(s).

STANDARDS:

1. Explain that examining a stool sample for occult blood is a simple and reliable method for determining subtle bleeding in the GI tract.
2. Explain that the cause of the bleeding may be found by directly visualizing the inside of the GI tract via an endoscope, a tube that is passed either by the mouth or the rectum.
3. Explain that sometimes defects of the GI tract that cause bleeding may be detected by x-ray by performing either a barium swallow or upper GI series or a barium enema.
4. Explain that the preparation for many of these procedures require that nothing be taken by mouth for several hours before the procedure, and enemas are usually required for the lower GI tests.
5. Explain that local anesthetics and sedation are usually given prior to the endoscopic procedures.

GIB-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the appropriate management of the gastrointestinal bleeding.

STANDARDS:

1. Explain that IV fluids and/or blood transfusions may be necessary to replace lost blood volume. **Refer to [BL](#).**
2. Explain that for upper GI bleeding, gastric lavage may be necessary to remove the blood from the GI tract and prevent further complications.
3. Explain that electrocoagulation or photocoagulation (laser) may be necessary to stop the bleeding.
4. Explain that surgery may be necessary to resect the bleeding area or tumor if other measures are not effective.

HTN-C COMPLICATIONS

OUTCOME: The patient will verbally summarize the complications of uncontrolled hypertension.

STANDARDS:

1. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
2. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that strokes may result from ruptures of injured blood vessels in the brain.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.

HTN-DP DISEASE PROCESS

OUTCOME: The patient will verbally define hypertension and summarize its causes.

STANDARDS:

1. Explain the difference between systolic and diastolic pressure. Define the normal ranges.
2. Review causative factors:
 - a. Lifestyle Factors: Obesity, high sodium intake, high fat and cholesterol intake, lack of regular exercise.
 - b. Special Conditions: Pregnancy, oral contraceptives.
 - c. Disease States: Diabetes, hyperthyroidism.
 - d. Personal Factors: Family history, sex, race.
3. Discuss that most hypertension is asymptomatic, but some patients may experience headache, dizziness, faintness, nosebleed, or ringing in the ears and any of these symptoms should prompt immediate re-evaluation by a physician.

HTN-EQ EQUIPMENT

OUTCOME: The patient/family will receive information on the use of home blood pressure monitors.

STANDARDS:

1. Provide the patient/family with information on the use of the specific home blood pressure monitor.
2. Discuss the use of blood pressure monitoring equipment in public places such as stores, etc.
3. Discuss when to contact a health care provider for a blood pressure value which is outside the patient's personal guidelines.

HTN-EX EXERCISE

OUTCOME: The patient will understand the relationship of exercise to normal blood pressure.

STANDARDS:

1. Explain how regular exercise helps to reduce high blood pressure and maintain normal blood pressure.
2. Discuss activity allowances and expectations (heavy lifting may predispose to complications).

HTN-FU FOLLOW-UP

OUTCOME: The patient participates in the treatment plan and understands the importance of adherence.

STANDARDS:

1. Discuss the individual's responsibility in the management of hypertension.
2. Encourage regular blood pressure and weight checks.
3. Review treatment plan with the patient, emphasizing the need to keep appointments, take medication as directed, make indicated lifestyle changes, and control co-morbid conditions.

HTN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hypertension.

STANDARDS:

1. Provide the patient/family with written patient information literature on hypertension.
2. Discuss the content of the patient information literature with the patient/family.

HTN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will have an understanding of the lifestyle adjustments necessary to maintain control of blood pressure and develop a plan to modify his/her risk factors.

STANDARDS:

1. Emphasize the importance of weight control.
2. Discuss the importance of a program of regular exercise.
3. Discuss the relationship of stress to hypertension. Suggest ways of reducing stress -- napping, meditation, exercise and "just relaxing."
4. Explain that use of tobacco, either smoking or use of smokeless tobacco, can worsen hypertension and increase the risk of complications.

HTN-M MEDICATIONS

OUTCOME: If on medication, the patient will verbally summarize their medication regimen and the importance of adherence with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications
2. Explain the importance of avoiding over-the-counter medications without checking with a physician.

HTN-N NUTRITION

OUTCOME: The patient will verbally summarize methods for control of blood pressure through weight control and diet modification.

STANDARDS:

1. Explain the role of salt intake in hypertension and ways to decrease salt intake.
 - a. Remove the salt shaker from the table.
 - b. Taste food before salting.
 - c. Discuss other seasonings.
 - d. Read food labels to determine sodium content.
2. Discuss caffeine and its role in hypertension.
3. Discuss the importance of weight loss in controlling hypertension.
4. Encourage adequate intake of fruits, vegetables, water and fiber.

INJ-CC CAST CARE

OUTCOME: The patient/family will understand the treatment plan and then importance of proper cast care.

STANDARDS:

1. Explain the reasons to care appropriately for the cast to improve healing.
2. Emphasize the importance of not placing foreign objects into the cast.
3. Explain the signs or symptoms that would prompt immediate follow-up, i.e., increased swelling, numbness, discoloration, increased pain.
4. Emphasize the importance of follow-up.

INJ-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family.
3. Emphasize safe use of equipment.

INJ-EX EXERCISE

OUTCOME: The patient/family will understand the exercises recommended or restricted as a result of this injury.

STANDARDS:

1. Discuss exercise recommendations or restrictions as they relate to the patient's injury.

INJ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the mechanism for obtaining follow-up.

INJ-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of injuries and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer falls, fewer emergency room visits, fewer hospitalizations and fewer complications.

INJ-I INFORMATION

OUTCOME: The patient/family will understand the pathophysiology of the patient's specific injury and recognize symptoms indicating a worsening of the condition.

STANDARDS:

1. Discuss the patient's specific injury, including anatomy and pathophysiology as appropriate.
2. Discuss the treatment plan and any indicated home management.
3. Discuss signs/symptoms of worsening of the condition and when to seek medical care.

INJ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about their specific injury.

STANDARDS:

1. Provide the patient/family with written information about the patient's injury.
2. Discuss the content of the patient information literature with the patient/family.

INJ-M MEDICATION

OUTCOME: The patient /family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of adherence with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

INJ-P PREVENTION

OUTCOME: The patient/family will understand mechanisms to prevent occurrence of similar injuries in the future.

STANDARDS:

1. Discuss safety measures which may be implemented to prevent the occurrence of a similar injury in the future.

INJ-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#)**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

INJ-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

LAB-DRAW PHLEBOTOMY

OUTCOME: The patient/family will understand the phlebotomy procedure.

STANDARDS:

1. Discuss the method of phlebotomy to be used for this lab draw.
2. Discuss common and important side effects or consequences of phlebotomy.

LAB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

LAB-L LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

LAB-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (gloves, etc.) and their role in preventing transmission of disease to the patient and the staff.
2. Discuss that needles and other lab draw equipment are single patient use and will be discarded after this draw.
3. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

LAB-TE TESTS

OUTCOME: The patient/family will understand the test to be performed.

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.
5. If the patient will obtain the specimen explain the procedure for properly obtaining the specimen and the storage of the specimen until it is returned to the lab.

OBS-C COMPLICATIONS

OUTCOME: The patient will be able to name at least 2 complications of obesity.

STANDARDS:

1. Emphasize that obesity is the single most important risk factor in Diabetes Mellitus Type 2.
2. Explain how obesity increases the risk for heart disease, infertility, cholelithiasis, musculoskeletal problems, and surgical complications.

OBS-DP DISEASE PROCESS

OUTCOME: The patient and family will have a basic understanding of the process underlying obesity and will be able to relate this process to changes necessary to attain improved health.

STANDARDS:

1. Relate obesity to health outcomes.
2. Emphasize the relationship among obesity, caloric intake, and exercise.
3. Explain that some people have a genetic predisposition to obesity which will require increased persistence to maintain health.

OBS-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in maintaining a healthy body weight, and will strive to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Stress the fact that exercise is a must in any weight loss program.

OBS-FU FOLLOW-UP

OUTCOME: The patient will understand that improved health requires a lifelong commitment to lifestyle adaptations which will assist with control of obesity.

STANDARDS:

1. Discuss the individual's responsibility in the management of obesity.
2. Review the patient's plan for lifestyle modification, emphasizing the need for keeping appointments, adhering to dietary modifications and increasing activity levels.
3. Encourage regular weight and blood pressure checks.
4. Reassess exercise and activity levels every 3-6 months.

OBS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about obesity.

STANDARDS:

1. Provide the patient/family with written patient information literature on obesity.
2. Discuss the content of the patient information literature with the patient/family.

OBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to attain a healthier body habitus.

STANDARDS:

1. Review dietary modifications and restrictions. **Refer to [OBS-N](#).**
2. Emphasize the benefits of regular exercise.
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options (fad diets, surgery, medications, etc.).

OBS-M MEDICATION

OUTCOME: The patient/family will understand that weight loss medications can have side effects or drug interactions and the importance of discussing any over-the-counter or prescription weight loss medications with the health care provider prior to initiating said medication(s).

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions of the medication with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (physician, pharmacist, nurse, etc.) of any drug interaction(s) that have occurred in the past.
4. Discuss the risk/benefit ratio of the medication(s) that are being considered.

OBS-N NUTRITION

OUTCOME: The patient will identify dysfunctional eating patterns and plan adaptations in eating which will promote weight loss and improved health.

STANDARDS:

1. Assess current eating patterns. Identify helpful and harmful components of the patient's diet.
2. Emphasize the importance of regular meal times and of eliminating snack foods, fatty foods, fatty red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables and fiber to the diet.
3. Emphasize the necessary component — water — in a healthy diet. Reduce the use of colas, coffee, and alcohol.
4. Review which community resources exist to assist with diet modification and weight control. Refer to dietitian as appropriate.
5. Anticipate psychological or social stressors which may lead to over-consumption. Teach the patient to splurge by plan, not by impulse.
6. Teach person(s) responsible for food purchase and preparation techniques for avoiding fats and simple carbohydrates in meal plans.

OBS-P PREVENTION

OUTCOME: The patient and family will understand the importance of attaining and maintaining a healthy body weight throughout the life span.

STANDARDS:

1. Emphasize that obesity often begins at conception. Discuss the roles of maternal obesity, gestational diabetes, and overfeeding of infants.
2. Encourage a physically active lifestyle.
3. **Refer to and [OBS-C](#).**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

PM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that the perception of pain is highly complex and individualized.

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.
4. Explain that touch type signals (rubbing, stroking, touching, etc.) may block the brain's reception of pain signals.

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (chronic, acute, malignant, etc.) and the causes of the patient's pain if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors and the measures that bring relief.
2. Emphasize the importance of communicating information about the pain to the provider.
3. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
4. Explain that pain tolerance varies greatly from person to person and in the same individual under different circumstances.
5. Explain that it is very rare for patients to become addicted to drugs administered for the relief of acute pain.

PM-EX EXERCISE

OUTCOME: The patient will understand the importance of exercise as a part of the pain management treatment plan.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression, and relieve some types of pain.
2. Encourage a program of regular exercise for optimal benefit.

PM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments
3. Emphasize that appointments should be kept.

PM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, pain management issues, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

PM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote healing.

STANDARDS:

1. Explain that treatment of pain is very individualized, i.e., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (familial, traditional, cultural, etc.) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate.
5. Refer to community resources as appropriate.

PM-M MEDICATION

OUTCOME: The patient/family will verbally summarize the medication regimen and the importance of adherence with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
3. Explain that chronic pain is usually irreversible and often progressive.
4. Discuss patient and family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.
5. Explain that insomnia and depression are often significant problems for chronic pain patients. Emphasize the importance of developing a plan with the provider to address these issues as appropriate
6. Explain that spiritual pain is a reality and cannot be relieved with medications.
7. Discuss the importance of adherence with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.

PM-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their pain and specific disease process. They will be able to identify foods and meal plans that will promote the healing process if applicable.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Review the patient's prescribed diet, if applicable. Refer to dietitian or other local resources as indicated.

PM-P PREVENTION

OUTCOME: The patient and/or family will understand the source of pain in relation to the appropriate disease process. They will make a plan to avoid the precipitating factors, minimize disease progression, promote healing; and/or maximize coping strategies.

STANDARDS:

1. Discuss importance of adherence to treatment plan for an acute injury to reduce the risk of residual chronic pain.
2. Discuss good body mechanics in order to reduce risk of musculoskeletal injuries.

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common with chronic pain and that depression may be seen and that treatments are available for these problems.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, adherence with the treatment regimen is important to maximize the effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, healing touch, herbal medicine, laughter, humor, traditional healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available such as support groups, individual therapy, family counseling, spiritual counseling, etc. Refer as appropriate.

PM-TE TESTS

OUTCOME: The patient and family will have an understanding of the tests to be performed.

STANDARDS:

1. Explain the test ordered (EMG, CT scan, ultrasound, etc.).
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Discuss any necessary preparation for the test(s).

PM-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., TENS units, heat, cold, massage.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to [PM-M](#).**
4. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

PC-DP DISEASE PROCESS

OUTCOME: The patient will verbalize understanding of the causes and symptoms of pancreatitis.

STANDARDS:

1. Explain that pancreatitis is an inflammation of the pancreas caused by activation of digestion enzymes produced by the pancreas.
2. Review the signs of pancreatitis (steady, boring pain radiating to the back or shoulder; low-grade fever; bulky, pale, foul-smelling stools; nausea and/or vomiting; abdominal distention, jaundice, etc.).
3. Relate some common causes (alcohol ingestion, biliary tract disease, postoperative, post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis, etc.).

PC-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of pancreatitis.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments and adhering to dietary modifications.
3. Emphasize the importance of regular medical follow-up and keeping clinic appointments.
4. Encourage participation in a self-help group, such as AA, if appropriate.

PC-L LITERATURE

OUTCOME: The patient/family will receive written information about pancreatitis.

STANDARDS:

1. Provide the patient/family with written patient information literature on pancreatitis.
2. Discuss the content of patient information literature with the patient/family.

PC - M MEDICATIONS

OUTCOME: The patient will understand the type of medication being prescribed, dosage and administration of the medication. They will also be aware of the proper storage of the medication and possible side effects of the drugs.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug

PC-N NUTRITION

OUTCOME: The patient will verbalize understanding of ways to minimize future episodes of pancreatitis through nutritional modifications.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between alcohol and pancreatitis.
3. Emphasize the importance of total abstinence from alcohol.
4. Encourage the patient to eat frequent, small meals that are bland and low fat.
5. Encourage the patient to avoid coffee.
6. Assist the patient to develop an appropriate diet plan.
7. Instruct that in many cases a regular diet may be very gradually resumed.
8. Refer to nutritionist as appropriate.

PC-P PREVENTION

OUTCOME: The patient will be able to identify factors related to pancreatitis and if appropriate verbalize a plan to prevent future episodes.

STANDARDS:

1. Explain that the major cause of pancreatitis in the US is alcohol ingestion.
2. Explain that if alcohol ingestion was a factor, that complete abstinence from alcohol will decrease the chance of future pancreatitis.
3. Explain that, in some cases, dietary changes may prevent attacks or reduce their severity.

PC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to [PM](#).**

PC-TX TREATMENT

OUTCOME: The patient will verbalize understanding of the treatment plan.

STANDARDS:

1. Explain that pancreatic secretions can be minimized by eliminating oral ingestion of food and fluid. This must be done to “rest” the pancreas.
2. Explain the proper use of pain medications. **Refer to [PM](#).**
3. Explain that, if the pancreatitis episode is prolonged, total parenteral nutrition may be required to maintain nutrition and promote healing.
4. Refer to community resources as appropriate.

XRAY-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications that may result from this procedure.

STANDARDS

1. Explain that some patients may have adverse reactions to contrast media or other medications used during radiographic/nuclear medicine procedures.
2. Discuss common and important complications as they apply to the procedure to be performed.
3. Discuss the procedure that will be undertaken if adverse events occur.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

XRAY-L LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

XRAY-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy as it relates to the procedure to be performed.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of adherence with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

XRAY-PRO PROCEDURE

OUTCOME: The patient/family will understand the radiographic/nuclear medicine procedure to be performed.

STANDARDS:

1. Discuss the method of the radiographic/nuclear medicine procedure that has been ordered.
2. Discuss the indications, risks, and benefits for the proposed procedure.
3. Explain the process and what to expect after the procedure.
4. Explain the necessary preparation, i.e., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

XRAY-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (lead shields, gloves etc.) and their role in preventing transmission of disease or unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Discuss as appropriate that needles and other infusion equipment are single patient use and will be discarded.
4. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

XRAY-TE TESTS

OUTCOME: The patient/family will understand the test to be performed.

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.

SWI-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with skin and wound infections.

STANDARDS:

1. Review with the patient/family the symptoms of a generalized infection, i.e., high fever spreading redness, red streaking, increased tenderness, changes in mental status, decreased urine output, etc.
2. Review with the patient/family the effects of uncontrolled skin or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for fasciotomy and skin grafting, multi-organ failure, death.
3. Inform patient/family that scarring and/or tissue discoloration may develop after healing of the wound.
4. Emphasis the importance of early treatment to prevent complications.

SWI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand cause and risk factors associated with skin and wound infections.

STANDARDS:

1. Review the current information regarding the causes and risk factors of skin and wound infections.
2. Explain how breaks in the skin can allow bacteria to enter the body.
3. Discuss importance of daily hygiene and skin inspection.
4. Explain that minor wounds should be kept clean and treated early to prevent serious skin or wound infections.
5. Explain that the use of immunosuppressive or corticosteroid medication may increase the risk for skin and wound infections.
6. Explain that elevated blood sugar increases the risk of serious skin and wound infections and impedes healing.
7. Review peripheral vascular disease and/or ischemic ulcers as appropriate.
8. Discuss with the patient/family the pathophysiologic process of an inflammatory response.

SWI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.

SWI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about skin and wound infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

SWI-M MEDICATION

OUTCOME: The patient/family will understand the importance of adherence with the prescribed medication regimen.

STANDARDS:

1. Discuss reason for specific medication in treatment of this patient's infection.
2. Review directions for use and duration of therapy.
3. Discuss expected benefits of therapy as well as the important and common side effects. Discuss side effects that should prompt a return visit.
4. Discuss importance of adherence with medication regimen and how completion of an antibiotic course will help prevent the development of antibiotic resistance.
5. Emphasize the importance of follow-up.

SWI-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent skin and wound infections.

STANDARDS:

1. Discuss avoidance of skin damage by wearing appropriate protective equipment, i.e., proper footwear, long sleeves, long pants, gloves, etc., as appropriate.
2. Explain importance of good general hygiene and cleaning any breaks in the skin and observing for infections.
3. Review importance of maintaining good general health and controlling chronic medical conditions, especially glycemic control in diabetes.

SWI-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that would prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling or pain, etc.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained and proper methods for disposal of used supplies.
5. Emphasize the importance of follow-up.

SPE-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the common and important complications of the proposed procedure.

STANDARDS:

1. Discuss the common and important complications of the proposed procedure.
2. Discuss alternatives to the proposed procedure.

SPE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Explain the procedure for obtaining appointments.

SPE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the surgical procedure or endoscopy.

STANDARDS:

1. Provide the patient/family with written patient information literature on the surgical procedure or endoscopy.
2. Discuss the content of the patient information literature with the patient/family.

SPE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

SPE-PO POSTOPERATIVE

OUTCOME: Patient and/or family will be knowledgeable about the post-operative course and home management as appropriate.

STANDARDS:

1. Review post-op routine.
2. Discuss symptoms of complications.
3. Review plan for pain management.
4. Discuss home management plan in detail, including signs or symptoms which should prompt re-evaluation.
5. Emphasize the importance of adherence with the plan for follow-up care.

SPE-PR PREOPERATIVE

OUTCOME: Patient/family will be prepared for surgery or other procedure.

STANDARDS:

1. Explain pre-operative preparation, including bathing, bowel preps, diet instructions, etc.
2. Explain the proposed surgery or other procedure including anatomy and physiology, alteration in function, risks, benefits, etc.
3. Discuss common or potentially serious complications.
4. Explain the usual pre-operative routine for the patient's procedure.
5. Discuss what to expect after the procedure.
6. Discuss pain management.

SPE-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, benefits, and common and important complications of the proposed procedure. Discuss the possible results of non-treatment.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, i.e., bowel preps, diet instructions, bathing.

SPE-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer, etc.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire, early death of a bread-winner.

TO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the slow progression of disease and disability associated with tobacco use.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Explain dependency and co-dependency.

TO-EX EXERCISE

OUTCOME: The patient/family will understand the role of an exercise program as part of rehabilitation and maintenance of tobacco abstinence.

STANDARDS:

1. Review the benefits of regular exercise, i.e., reduced stress, weight control, increased self-esteem and overall sense of wellness.

TO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

TO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tobacco use or cessation of use.

STANDARDS:

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.
2. Discuss the content of the patient information literature with the patient/family.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and healthy "replacement habits".

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of complying with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Briefly review the mechanism of action of the medication if appropriate.
3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.
4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and adhere to it.

TO-QT QUIT

OUTCOME: The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

STANDARDS:

1. Discuss the importance of quitting tobacco use now and completely.
2. Establish a quit date and plan of care.
3. Review the treatment and support options available to the patient and family.
4. Review the value of close F/U and support during the first months of cessation.

TO-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define “passive smoking”, ways in which exposure occurs:
 - a. smoldering cigarette, cigar, or pipe
 - b. smoke that is exhaled from active smoker
 - c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke
 - a. nicotine
 - b. benzene
 - c. carbon monoxide
 - d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of ulcerative colitis are colon perforation, hemorrhage, toxic megacolon, abscess formation, stricture, anal fistula, malnutrition,, anemia, electrolyte imbalance, skin ulceration, arthritis, ankylosing spondylitis, and cancer of the colon.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is an inflammatory disease of the mucosa and, less frequently, the submucosa of the colon and rectum.
2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity and familial predisposition.
3. Explain that this disease is most common during young-adulthood to middle life.
4. Explain that the symptoms are diarrhea, abdominal cramping, weight loss, anorexia, nausea, vomiting and abdominal pain.
5. Explain that ulcerative colitis is characterized by remissions and exacerbations.
6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the specific bowel disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding colon disease.
2. Discuss the content of the patient information literature with the patient/family.

UC-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed.
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

UC-N NUTRITION

OUTCOME: The patient/family will have an understanding of how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Advise the patient to avoid dairy products if the patient is lactose intolerant.
3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.
4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet.
5. Advise the patient to avoid cold or carbonated foods or drinks which increase intestinal motility.
6. Assist the patient/family in developing appropriate meal plans. Encourage frequent, small meals and chew food thoroughly.
7. Explain that supplementation with vitamins and minerals may be necessary.
8. Refer to dietitian as appropriate.

UC-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

UC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.
2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
3. Explain that short term use of narcotics may be helpful in acute pain management
4. Advise the patient not to use over the counter pain medications without checking with his/her provider

UC-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
 - a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
 - b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Upper gastrointestinal barium studies
 - a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
 - b. Explain that barium liquid will be swallowed and radiographs taken.
3. Barium Enema
 - a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
 - b. Explain that barium liquid will be introduced by enema and radiographs taken.
 - c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

UC-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the appropriate treatment for ulcerative colitis and verbalize a plan to adhere to the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. Bedrest
 - b. IV fluid replacement to correct dehydration
 - c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance
 - d. Sulfasalazine, for its antibacterial and anti-inflammatory effects
 - e. Corticosteroids, systemically or by rectal instillation, to decrease inflammation
 - f. Colectomy
2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

General Education Codes - Guidelines For Use

These general education codes were developed in response to the ever-expanding list of patient education codes. The following 17 codes are education topic modifiers which can be used in conjunction with any ICD-9 diagnosis to document patient and family education. The following list is NOT exhaustive, nor is it intended to be. If a provider requires more specific education coding the previously developed codes are still available for use and are preferred where applicable.

This newer, more general system is used in essentially the same way as the existing codes, except that instead of having a patient education diagnosis code the provider will simply write out the diagnosis or condition, followed by the education modifier, followed by level of understanding, and finally the provider initials. For example:

Head lice - TX - P - <provider initials>

This would show up on the health summary under the patient education section as:

Head lice - treatment - poor understanding.

If education on more than one topic on the same diagnosis is provided these topics can be separated by commas IF the level of understanding is the same for each topic. For example:

Head lice-P,TX,M,FU-G-<provider initials>.

This would be show up on the health summary under the patient education section as:

Head lice - prevention, treatment, medication, follow-up - good understanding.

If education is provided on multiple diagnoses and/or the level of understanding varies these must be documented separately. For example:

Head lice - P - P - <provider initials>

Head lice - TX - G - <provider initials>

Impetigo - M, FU - G - <provider initials>

This would show up on the health summary under the patient education section as:

Head lice - prevention - poor understanding

Head lice - treatment - good understanding

Impetigo - medications, follow-up - good understanding

Please note that the diagnosis MUST have an associated ICD-9 diagnosis code. These codes must still be documented in the patient education section of the PCC. The levels of understanding have not changed and are **G=good, F=fair, P=poor, R=refused, and Gp=group.**

The committee would like to thank Lisa Hakanson, R.D. for her suggestion that resulted in this addition.

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the system(s) involved.
2. Discuss the changes to anatomy and physiology as a result of this disease process or condition (as applicable).
3. Discuss the impact of these changes on the patient's health or well-being.

C - COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of this disease state/condition, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/condition.
2. Discuss common or significant complications which may be prevented by adherence with the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

DP - DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness or condition.

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
2. Discuss the signs/symptoms and usual progression of this disease state/condition.
3. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

EQ - EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of home medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O₂, use of gloves, electrical cord safety, and disposal of sharps.
6. Discuss proper disposal of associated medical supplies.

EX - EXERCISE

OUTCOME: The patient/family will have an understanding of the relationship of physical activity to this disease state, condition or to health promotion and disease prevention and develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Review the basic exercise or activity recommendations for the treatment plan.
3. Discuss the relationship of increased exercise or limited physical activity as applicable to this disease state/condition.
4. Assist the patient/family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

HM - HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits, fewer hospitalizations, and fewer complications.
3. Explain the use and care of any necessary home medical equipment.

HY - HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits.
3. Discuss the importance of hand-washing in infection control.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

L - PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

LA - LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and adherence with treatment plan.
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

M - MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of adherence with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

N - NUTRITION

OUTCOME: The patient will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease state/condition.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

P - PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition, i.e., immunizations, hand washing, exercise, proper nutrition, use of condoms, etc.
3. Assist the patient in developing a plan for prevention.

PRO - PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, i.e., bowel preps, diet instructions, bathing.
4. Discuss pain management as appropriate.
5. Emphasize post-procedure management and follow-up.

S - SAFETY

OUTCOME: The patient/family will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol and/or drugs while in a vehicle.
3. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., poison control, secure electrical cords, fire prevention.
4. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
5. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, i.e., 911, Poison Control, hospital ER, police.

TE - TESTING

OUTCOME: The patient/family will have an understanding of the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the meaning of test results.

TX - TREATMENT

OUTCOME: The patient/family will have an understanding of the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

**MNT MEDICAL NUTRITION THERAPY (FOR USE BY REGISTERED
DIETICIANS ONLY)**

MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. Assessment must include review and analysis of medical and diet history, lab values, and anthropometric measurements. MNT is based on assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury.

MNT plays a key role throughout the continuum of care in all practice settings and phases of the life cycle, from prenatal care to care of the elderly. After nutrition screening identifies those at risk, appropriate MNT leads to improved health outcomes resulting in improved quality of life and cost savings.

The Dietetic Practitioner also referred to, as a Registered Dietitian is the only member of the health care team uniquely qualified to provide MNT.

REGISTERED DIETICIAN: An individual who has completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university or foreign equivalent, has met current minimum academic requirements and complete pre-professional experience, has successfully completed the Registration Examination for Dietitians, and has accrued 75 hours of approved continuing professional education every 5 years.

**INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES**

BAR-BLND BLIND

OUTCOME: The patient states or demonstrates the inability to see, or the patient's inability to see is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can read Braille.

BAR-COGI COGNITIVE IMPAIRMENT

OUTCOME: The patient states or demonstrates an inability to comprehend new information, or, the patient has a documented cognitive impairment problem.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine adaptive approaches to learning that can be utilize.
3. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-DEAF DEAF

OUTCOME: The patient states or demonstrates the inability to hear, or, the patient's inability to hear is documented.

STANDARDS:

1. Assess the type of deafness (cause by such as accident, illness or disease).
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Assess Sign language ability and as needed obtain a sign interpreter.
4. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
5. Determine if patient can communicate through writing.
6. Assess and document the on-set of deafness.

BAR-DNRE DOESN'T READ

OUTCOME: The patient states or demonstrates an inability to read, or the patients' inability to read English is documented.

STANDARDS:

1. Ask patient/family if patient reads English.
2. Ask patient/family if patient reads in their primary language. If yes, what language is that?
3. Assess patient's English literacy level (English may be a second language).
4. Provide appropriate written materials.
5. Plan with patient/family about approaches to learning other than reading.

BAR-EMOI EMOTIONAL IMPAIRMENT

OUTCOME: The patient's ability to learn is limited due to an emotional impairment.

STANDARDS:

1. Assess the type and degree of emotional impairment (mood disorder, psychotic symptoms, acute stress, anxiety, depression, etc.).
2. Provide the minimum amount of information needed with simple written information for reinforcement.
3. Refer to Mental Health for assessment and intervention.
4. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

OUTCOME: The patient states or demonstrates fine motor skills impairment, like checking blood sugars or measuring medications, or, the patient has a documented fine motor skills deficit.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.

BAR-HEAR HARD OF HEARING

OUTCOME: The patient states or demonstrates a problem with hearing, or, the patient's hearing impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.
3. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
4. Determine if patient can communicate through writing.

BAR-INTN INTERPRETER NEEDED

OUTCOME: For patients who do not readily understand spoken English, an Interpreter is made available.

STANDARDS:

1. Identify the patient's primary language.
2. Determine their preferred language.
3. As appropriate, obtain an interpreter.

BAR – NONE NO BARRIERS

OUTCOME: The patient/family has no apparent barriers to learning.

STANDARDS:

1. Through interview and /or observation, determine or rule out any barriers that may affect ability to learn.

BAR-STRS SOCIAL STRESSORS

OUTCOME: The patient's ability to learn is limited due to social stressors.

STANDARDS:

1. Assess acute and on-going social stressors (e.g., family separation and conflict, disease, divorce, death, alcohol/substance abuse, domestic violence, etc.).
2. Provide the minimum amount of information needed with simple written information for reinforcement. As appropriate defer additional education until crisis is over.
3. Refer to social services or mental health for assessment and/or subsequent referrals.
4. Set-up a date for follow-up assessment as indicated.

BAR-VALU VALUES/BELIEF

OUTCOME: Define what is meant by "value" and "belief." Identify differences in patients and provider's values and beliefs.

Note: There is frequently a discrepancy between what patients value and believe versus what providers think is important (about self-care issues). Initiate open dialogue with the patient. Discuss differences and establish common ground on what the patient is willing to do concerning their health.

Value - A principal, standard, or quality regarded as worthwhile or desirable to the client.

Belief - Something believed or accepted as true by the client.

STANDARDS:

1. Attempt to verbalize the difference(s).
2. Ask questions to clarify patients prospective.
3. Try to identify areas of agreement.
4. Address areas for which there is agreement.
5. Discuss the concept of Locus of Control with patient. Which statement below best describes how the patient sees his/her ability to affect his/her health?
 - a. I can control my life/health through my own effort
 - b. My doctor/family member/friends control my life/health
 - c. I am powerless to affect my life/health

BAR-VISI VISUALLY IMPAIRED

OUTCOME: The patient states or demonstrates difficulty with vision, or the patient's visual impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can communicate through writing.

LP-DOIT DO/PRACTICE

OUTCOME: The patient/family will verbalize that by doing or practicing a new skill is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, “In what way or ways do you learn best?”

LP-GP SMALL GROUP

OUTCOME: The patient/family will verbalize that participating in small groups is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, “In what way or ways do you learn best?”

LP-READ READ

OUTCOME: The patient/family will verbalize that reading is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, “In what way or ways do you learn best?”

LP-TALK TALK

OUTCOME: The patient/family will verbalize that talk is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-VIDEO VIDEO

OUTCOME: The patient/family will verbalize that viewing videos is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

RL-DSTR DISTRACTION

OUTCOME: The patient is unable to learn because of distractions.

STANDARDS:

1. Acknowledge that the environment contains distractions to learning such as noise or young children.
2. Determine any action that could negate or minimize the distraction.
3. Consider deferring educational session until stimuli causing distraction is no longer an issue.

RL – EAGR EAGER TO LEARN

OUTCOME: The patient/family verbalizes or demonstrates a level of eagerness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL – RCPT RECEPTIVE

OUTCOME: The patient/family verbalizes or demonstrates a receptive level of readiness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL-PAIN PAIN

OUTCOME: The patient verbalizes or demonstrates through the use of body language a certain level of pain.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess their level of pain. Does the patient require pain medication? If so, when was their last dose administered?
3. If appropriate, ask the patient for his/her attention to the subject matter.
4. Observe his/her response to your request or to your presentation of the subject matter.
5. Consider deferring or terminating the educational session if the patient is experiencing a high level of pain or is being medicated for pain.

RL-SVIL SEVERITY OF ILLNESS

OUTCOME: The patient/family will be unable to gain new knowledge due to a condition or severity of illness that would impair or prevent learning.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess the severity of their illness. Consider their level or "alertness."
3. Determine if family is available to assist with the patients care. Assess the family's readiness to learn.
4. If appropriate, ask the patient/family for their attention to the subject matter.
5. Observe their response to your request or to your presentation of the subject matter.
6. Consider deferring or terminating the educational session if the patient is experiencing complications from the illness that may distract the family's attention.

RL-UNRC UNRECEPTIVE

OUTCOME: The patient/family verbalizes or demonstrates an unreceptive level of readiness to learn at the beginning of a teaching encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.
4. Ask or suggest to patient/family if they would like to meet at another time for education session.

INDEX OF PATIENT EDUCATION PROTOCOLS

ABD ABDOMINAL PAIN

ABD-C	Complications
ABD-DP	Disease Process
ABD-FU	Follow-up
ABD-L	Patient Information Literature
ABD-M	Medications
ABD-N	Nutrition
ABD-PM	Pain Management
ABD-TE	Tests
ABD-TX	Treatment

ADV ADVANCE DIRECTIVES

ADV-I	Information
ADV-L	Patient Information Literature
ADV-LW	Living Will
ADV-POA	Durable Power Of Attorney For Health Care
ADV-RI	Patient Rights And Responsibilities

AN ANEMIA

AN-C	Complications
AN-DP	Disease Process
AN-FU	Follow-up
AN-L	Patient Information Literature
AN-M	Medications
AN-N	Nutrition
AN-PRO	Procedures
AN-TE	Tests
AN-TX	Treatments

ANS ANESTHESIA

ANS - C	Complications
ANS-EQ	Equipment
ANS - FU	Follow-up
ANS-INT	Intubation
ANS - L	Literature
ANS-PM	Pain Management
ANS - PO	Postoperative
ANS-PR	Preoperative

BL BLOOD TRANSFUSION

BL-C	Complications
BL-FU	Follow-up
BL-L	Patient Information Literature
BL-S	Safety
BL-TX	Treatment

CA CANCER

CA-AP	Anatomy and Physiology
CA-C	Complications
CA-DP	Disease Process
CA-EQ	Equipment
CA-FU	Follow-up
CA-HM	Home Management
CA-L	Literature
CA-LA	Lifestyle Adaptations
CA-M	Medications
CA-N	Nutrition
CA-P	Prevention
CA-PM	Pain Management
CA-REF	Referral
CA-TE	Tests
CA-TX	Treatment

CPM CHRONIC PAIN

CPM-DP	Disease Process
CPM-EX	Exercise
CPM-FU	Follow-Up
CPM-L	Patient Information Literature
CPM-LA	Lifestyle Adaptations
CPM-M	Medications
CPM-S	Safety

CRN CROHN'S DISEASE

CRN-C	Complications
CRN-DP	Disease Process
CRN-FU	Follow-up
CRN-L	Patient Information Literature
CRN-M	Medications
CRN-N	Nutrition
CRN-P	Prevention
CRN-PM	Pain Management
CRN-TE	Tests
CRN-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

DM DIABETES MELLITUS

DM-C	Complications
DM-DP	Disease Process
DM-EQ	Equipment
DM-EX	Exercise
DM-FTC	Foot Care And Examinations
DM-FU	Follow-up
DM-HM	Home Management
DM-KID	Kidney Disease
DM-L	Patient Information Literature
DM-LA	Lifestyle Adaptations
DM-M	Medications
DM-N	Nutrition
DM-P	Prevention
DM-PM	Pain Management
DM-WC	Wound Care

DIV DIVERTICULITIS /DIVERTICULOSIS

DIV-C	Complications
DIV-DP	Disease Process
DIV-FU	Follow-up
DIV-L	Patient Information Literature
DIV-M	Medications
DIV-N	Nutrition
DIV-P	Prevention
DIV-PM	Pain Management
DIV-TE	Tests
DIV-TX	Treatment

DYS DYSRHYTHMIAS

DYS-C	Complications
DYS-DP	Disease Process
DYS-EQ	Equipment
DYS-FU	Follow-up
DYS-L	Patient Information Literature
DYS-M	Medications
DYS-TE	Tests
DYS-TX	Treatment

F FEVER

F-C	Complications
F-DP	Disease Process
F-FU	Follow-up
F-HM	Home Management
F-L	Patient Information Literature
F-M	Medications

FRST FROSTBITE

FRST-C	Complications
FRST-DP	Disease Process
FRST-FU	Follow-up
FRST-L	Patient Information Literature
FRST-M	Medications
FRST-N	Nutrition
FRST-P	Prevention
FRST-PM	Pain Management
FRST-TX	Treatment
FRST-WC	Wound Care

GB GALLBLADDER DISORDERS

GB-AP	Anatomy and Physiology
GB-C	Complications
GB-DP	Disease Process
GB-FU	Follow-up
GB-L	Literature
GB-M	Medications
GB-N	Nutrition
GB-P	Prevention
GB-PM	Pain Management
GB-PRO	Procedures
GB-TE	Tests

GER GASTROESOPHAGEAL REFLUX DISEASE

GER-DP	Disease Process
GER-FU	Follow-up
GER-L	Patient Information Literature
GER-LA	Lifestyle Adaptations
GER-M	Medications
GER-N	Nutrition
GER-PM	Pain Management
GER-TE	Tests
GER-TX	Treatment

GIB GI BLEED

GIB-C	Complications
GIB-DP	Disease Process
GIB –FU	Follow-up
GIB –L	Patient Information Literature
GIB -M	Medications
GIB –N	Nutrition
GIB –P	Prevention
GIB-TE	Tests
GIB-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

HTN HYPERTENSION

HTN-C	Complications
HTN-DP	Disease Process
HTN-EQ	Equipment
HTN-EX	Exercise
HTN-FU	Follow-up
HTN-L	Patient Information Literature
HTN-LA	Lifestyle Adaptations
HTN-M	Medications
HTN-N	Nutrition

INJ INJURIES

INJ-CC	Cast Care
INJ-EQ	Equipment
INJ-EX	Exercise
INJ-FU	Follow-up
INJ-HM	Home Management
INJ-I	Information
INJ-L	Patient Information Literature
INJ-M	Medication
INJ-P	Prevention
INJ-PM	Pain Management
INJ-WC	Wound Care

LAB LABORATORY

LAB-DRAW	Phlebotomy
LAB-FU	Follow-up
LAB-L	Literature
LAB-S	Safety
LAB-TE	Tests

OBS OBESITY

OBS-C	Complications
OBS-DP	Disease Process
OBS-EX	Exercise
OBS-FU	Follow-up
OBS-L	Patient Information Literature
OBS-LA	Lifestyle Adaptations
OBS-M	Medication
OBS-N	Nutrition
OBS-P	Prevention

PM PAIN MANAGEMENT

PM-AP	Anatomy and Physiology
PM-DP	Disease Process
PM-EX	Exercise
PM-FU	Follow-up
PM-L	Patient Information Literature
PM-LA	Lifestyle Adaptations
PM-M	Medication
PM-N	Nutrition
PM-P	Prevention
PM-PSY	Psychotherapy
PM-TE	Tests
PM-TX	Treatment

PC PANCREATITIS

PC-DP	Disease Process
PC-FU	Follow-up
PC-L	Literature
PC-M	Medications
PC-N	Nutrition
PC-P	Prevention
PC-PM	Pain Management
PC-TX	Treatment

XRAY RADIOLOGY/NUCLEAR MEDICINE

XRAY-C	Complications
XRAY-FU	Follow-up
XRAY-L	Literature
XRAY-M	Medications
XRAY-PRO	Procedure
XRAY-S	Safety
XRAY-TE	Tests

SWI SKIN AND WOUND INFECTIONS

SWI-C	Complications
SWI-DP	Disease Process
SWI-FU	Follow-up
SWI-L	Patient Information Literature
SWI-M	Medication
SWI-P	Prevention
SWI-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

SPE SURGICAL PROCEDURES AND ENDOSCOPY

SPE-C	Complications
SPE-FU	Follow-up
SPE-L	Patient Information Literature
SPE-PM	Pain Management
SPE-PO	Postoperative
SPE-PR	Preoperative
SPE-PRO	Procedures
SPE-WC	Wound Care

TO TOBACCO USE

TO-C	Complications
TO-DP	Disease Process
TO-EX	Exercise
TO-FU	Follow-up
TO-L	Patient Information Literature
TO-LA	Lifestyle Adaptations
TO-M	Medications
TO-QT	Quit
TO-SHS	Second-Hand Smoke

UC ULCERATIVE COLITIS

UC-C	Complications
UC-DP	Disease Process
UC-FU	Follow-up
UC-L	Patient Information Literature
UC-M	Medications
UC-N	Nutrition
UC-P	Prevention
UC-PM	Pain Management
UC-TE	Tests
UC-TX	Treatment

GENERAL EDUCATION TOPICS

AP - Anatomy and Physiology
C - Complications
DP - Disease Process
EQ - Equipment
EX - Exercise
FU - Follow-up
HM - Home Management
HY - Hygiene
L - Patient Information Literature
LA - Lifestyle Adaptations

M - Medications
N - Nutrition
P - Prevention
PRO - Procedures
S - Safety
TE - Testing
TX - Treatment
MNT-Medical Nutrition Therapy (For Use By
Registered Dieticians Only)

INDEX OF PATIENT EDUCATION PROTOCOLS

EDUCATION NEEDS ASSESSMENT CODES

BAR-BLND	Blind	LP-GP	Small Group
BAR-COGI	Cognitive Impairment	LP-READ	Read
BAR-DEAF	Deaf	LP-TALK	Talk
BAR-DNRE	Doesn't Read	LP-VIDO	Video
BAR-EMOI	Emotional Impairment	RL-DSTR	Distraction
BAR-FIMS	Fine Motor Skills Deficit	RL – EAGR	Eager To Learn
BAR-HEAR	Hard Of Hearing	RL – RCPT	Receptive
BAR-INTN	Interpreter Needed	RL-PAIN	PAIN
BAR – NONE	No Barriers	RL-SVIL	Severity of Illness
BAR-STRS	Social Stressors	RL-UNRC	Unreceptive
BAR-VALU	Values/Belief		
BAR-VISI	Visually Impaired		
LP-DOIT	Do/Practice		